The Journal

Vol. 7 No. 1 | 2nd Class Mail Reg. No. 2776 | **Published monthly by Addiction Research Foundation** | TORONTO January 1, 1978

JAN 13 1978
Humanities & Social Sciences

Self help is the key for developing countries

Highly organized Western methods of dealing with alcohol and drug dependence are almost irrelevant in developing countries, says Narendra Wig, one of India's leading psychiatrists. A country like India, with more than 600 million people, needs programs that can be operated on a broad base by village workers, Dr Wig told an international seminar marking the Addiction Research Foundation's designation as a World Health Organization collaborating centre for research and training on drug dependence. A special four-page report on the ARF — WHO seminar, by Anne MacLennan, begins on page 7.



Coca leaves on sale in the Indian Market, La Paz, Bolivia.

Photo: Harvey McConnell

Cocaine brain damage being seen in Bolivia

Apparently irreversible brain damage, in Bolivians who smoke cocaine paste, or inhale a nearly pure form of the drug, is being found by Nils Noya, director of Bolivia's National Institute of Drug Dependence. In his first reports from South America, Harvey McConnell examines Dr Noya's findings, efforts by South American countries to simplify extradition of traffickers, and the situation in Colombia, shipping point for cocaine and marijuana to North America and Europe. Page 4.

World dodging pot issues

Increasing and widespread use of cannabis is one of "the most incredible changes in behavior, globally, in the drug field," says Robert DuPont, director of the United States National Institute on Drug Abuse. Yet, it appears people are "turning the other direction and saying nothing about it," says Dr DuPont. Page 8.

Backgrounder

In November, 1977, the Addiction Research Foundation of Ontario was designated a World Health Organization collaborating centre. This month, H. David Archibald, executive vice-chairman of the ARF, discusses with Anne MacLennan, the meaning and significance of the designation. Page 11.

Addicted women turn to streets

Most prostitutes walking the streets are addicted to drugs, mainly heroin, claims Margo St James, a "retired" prostitute, and founder of COYOTE, a prostitute's guild in the United States. Drugs and prostitution should be decriminalized at the same time to reduce both the visibility and vulnerability of street walkers, she says. Page 3.

Regular features

- Wayne Howell 2
- Letters to Editor 6
- Inside Science 11
- Factsheet 13
- New Books 14
- Coming Events 15

Canada's drug bureau balking on secret files

By Bryne Carruthers

OTTAWA — The federal Bureau of Dangerous Drugs is digging in its heels on its right to maintain its controversial secret files on known drug users, including files on some 163,000 Canadians listed as "known cannabis users."

In a rationalization that may require testing under the just-proclaimed (Jan 1) privacy provisions of the Human Rights Act, the bureau now maintains that much of the information contained in the files relates to police reports which must be supplied, by law, to the health department, so that the Canadian health minister can determine how to dispose of drugs, money, automobiles, and other goods seized in connection with drug crimes.

The bureau uses this same information, along with drug conviction reports, drug treatment clinic reports, other police reports, and physicians' reports, as the basis for compiling hard copy and computerized files on known and suspected users of various drugs, including cannabis.

This happens despite the fact the "disposition" reports from the police were not originally supplied to the health department for use in generating drug user files or statistics.

The bureau argues the minister of health has a broad responsibility to gather information on drug use and users in Canada and that it is not illegal to use such information.

More startling is the revelation that the health department receives hundreds of complaints each year from third parties (including neighbors) on suspected drug users or drug crimes.

These allegations are included in personal drug files maintained by the bureau and are usually referred to the police for investigation.

As a matter of courtesy, the police normally provide the bureau with a copy of their investigation report, which is then also added to individual drug user files.

The latest revelations and explanations leave unanswered the questions of whether an individual with a cannabis file can see the contents of his or her file; and what information an individual could correct in his file.

The health department says its policy on these and related issues will have to await the federal government's position on the new privacy provisions of the human rights legislation, as well as the exceptions to be provided for in privacy regulations expected later this month.

While it is expected certain information contained in an individual's file will be made available to that individual, it is also clear the department plans to resist making other information in the file available, especially that relating to third parties or to the sources of information on an individual.

Also in limbo for the time being, is the idea that the cannabis user statistics would be compiled using only publicly available drug conviction information, instead of also using information from non-public sources such as police reports, doctors' reports, and third party reports.

The department had earlier indicated the drug files kept by the department would be vetted of any information relating to cannabis use that was not available from drug conviction records.

As it now stands, information could still be entered into an individual's file at the "laying of charges" stage, perhaps even before this stage, using information from police and other sources, even though an individual might later be acquitted of a charge.

The health department argues that there is no threat to civil liberties at stake, since the information in the files is not made available to police forces or any others outside the Bureau of Dangerous Drugs, and since it is normally used only for statistical purposes.

Canadian-Mexican agreement

Prisoner exchange doesn't change law threat

OTTAWA — Canada and Mexico have finally signed a prisoner exchange agreement that will allow a dozen Canadians being held in Mexican jails for drug convictions, eventually to spend the rest of their penal careers in brighter, more comfortable surroundings in Canada.

The agreement, which must still be ratified by the Canadian parliament, is the culmination of a series of horror stories emanating from Mexican jails, most of them involving Canadians caught and convicted of drug crimes such as cocaine smuggling.

A year ago, half a dozen of the Canadians in Mexican jails joined a prisoners' hunger strike in an effort to convince the Mexican government to end discriminatory treatment that prohibited paroles for drug crimes: people caught with drugs in Mexico fall into a special category, the only one for which parole isn't granted.

The elimination of parole in 1971 was part of a cooperative effort by Mexico and the United States to reduce drug smuggling.

The Canadian prisoner exchange agreement follows the lead established by the United States when it signed a similar agreement with Mexico in 1976. Early in 1977, Canada signed a similar agreement with the US.

At last count, there were 13 Canadians being held in Mexican jails, and one Mexican being held in a Canadian jail, that would benefit from the new Canada-Mexico prisoner exchange treaty, once it is ratified in both countries.

The exchange only applies to prisoners whose rights of appeal have been exhausted in the sentencing country.

For this and other reasons, Mexico will still be a threat to Canadians caught possessing, trafficking in, or smuggling drugs.

For example, more often than not, a year or more elapses before individuals are actually brought to trial in Mexico. And in cases involving drugs, people can expect to be held in one of those storied Mexican jails until the trial.

The new treaty has other problems as well. Even after prisoners are returned to Canada, they can expect to spend more time in jail than individuals convicted of the crime within Canada. In effect, Canada would have to agree to carry out more severe Mexican punishment, when meted out, than Canadian law might require under similar circumstances.

Mexico had very good reason to enter into the special prisoner exchange agreements with Canada and the United States: tourist trade from both countries has been down sharply in recent years, largely as a result of the bad reputation Mexico has been getting in relation to crime, its ponderous system of justice, and its lack of comfortable jail conditions.

Alcoholics: doctor fees a key factor

WASHINGTON — A critical factor in how the private doctor reacts to alcoholic patients is tied to the "getting and keeping" syndrome, according to Mansell Pattison, of the University of California at Irvine.

It boils down to: "How do I get patients, and once I have got them how do I keep them so they pay me," Dr Pattison told the national conference on medical education in alcohol and drug abuse here.

He said: "We are trying to teach physicians how to interact with patients in ways that arouse patient resentment, hostility, frustration, and suspicion. No wonder we run up against a wall.

"It is not just the attitude of the private physician we are running up against, it is the sociological, political, and economic reality.

"The economics of a doctor keeping patients is really important, and we have not really addressed that issue."

Dr Pattison said most alcohol and drug abuse education is focused on the medical students, yet studies that do exist show most attitudes are formed during the residency years. "A lot of what they have learned as medical students tends to be radically wiped out as to what they learn as residents."

Medical education is still organ-disease oriented, "whereas alcoholism is a person problem," Dr Pattison continued.

"I would suggest that, by and large, alcoholics enter the medical system and get reasonably decent treatment for their organ pathology, but get no treatment for their alcoholism, which is a person problem, any more than any other patient with a person problem in medicine gets good treatment."

Dr Pattison said the alcoholic is not alone among those who need multiple agency care, and because of this does not get good treatment.

"If we just attack the problem of alcoholism without really paying attention to the totality of the lack of person orientation of medical education, we are not going to get any place with alcoholism," he added.

Another drawback is that there are few, if any, models of continuity of care that are whole-person and family-oriented which can be used in medical education.

While Dr Pattison has cordial relations with most AA groups, and has worked with many, there are some members who talk to students "with a very strong ideological AA pitch, with its anti-medicine, anti-therapeutic, and anti-establishment pitch.

"Most medical students are turned off. They think: 'if that's the treatment for alcoholics, fine, let them go and treat the drunks.'

"We need to help in interpreting the role of AA."

American Acronym Acolytes (AAA) hit by IAA

By Wayne Howell



Most Americans working in the alcohol and drug abuse field were shocked by the motion of censure passed recently at the International Acronym Association's biennial congress in Geneva.

Not a few of them have expressed the feeling that the motion condemning them for "showing a callous disregard for the principles of acronym assembly" and for "wilfully producing acronyms without grace or wit" was just another example of a UN style gang-up to harass and humiliate the United States. The IAA is, of course, known for its exacting standards.

But the harsh tone of the censure motion still came as a surprise to many people.

I raised this point with Sir Percival Twiltingham O.B.E., international president of the IAA:

"The resolution was passed more in sadness than in anger. The American bureaucracy has, over the years, produced some of the finest acronyms known to man. For instance, who can forget VISTA (Volunteers In Service To America). But there is only one word for the acronyms churned out by the alcohol and drug bureaucracy and that word is *shoddy*."

Harsh words from Sir Percival. But there are some Americans who, while condemning the resolution, will candidly admit alcohol and drug acronyms have not been all they should have been. One senior bureaucrat told me ADAMHA (Alcohol Drug Abuse and Mental Health Administration) had always been anathema to him. And there were very few who took particular pride in SAODAP (Special Action Office for Drug Abuse Prevention). These awkward acronyms were, of course, roundly condemned in the IAA resolution, on the grounds that not only did they not spell a recognizable word, they were difficult to pronounce as well.

"We see these abominable acronyms as a violation of IAA's first principle," explained Sir Percival, "which is that if you cannot produce a decent word that makes some sort of sense then you should not force it, you should retreat back to a three letter non-acronym: we don't begrudge the American bureaucrats their HEW, their HUD, and the OMB. But we strongly object to odious conglomerations of letters like SAODAP — the IAA has never even been able to ascertain if that is pronounced *say-o-dap* or *sew-dap!*"

I asked Sir Percival if the American decision to drop SAODAP and start ODAP (Office for Drug Abuse Policy) had any effect upon the IAA's deliberations. Did they see this as an indication that the Americans were not completely beyond the pale, they were not completely without acronymic acumen?

"ODAP is almost as offensive to us as SAODAP," said Sir Percival, "for it violates the IAA's second principle: if you cannot produce a recognizable word with at least a tenuous association with the purposes of the organization then at least your non-word should trip off the tongue with a reasonable degree of facility. The Americans seem to have no feel for this at all. ODAP is not to be condoned because it begins with a vowel followed by a hard consonant. A conscientious acronym assembler would have created a Drug Abuse Prevention Office — DAPO. DAPO is much more pleasing to the ear than ODAP; just say them out loud and you will see what I mean."

The ODAP/DAPO quibble seemed trivial to me (Sir Percival was also of the opinion that NIDA would have been better rendered as DANI — Drug Abuse National Institute) and I was compelled to ask if there was any American alcohol and drug acronym the IAA *did* like.

"CODAP", said Sir Percival, "was considered by some IAA members to be a rather elegant acronym because of the built-in pun. Do you get it? A Client Oriented Data Aquisition Process is a way of 'codnig' information."

Apparently, this rose among thorns was not enough to thwart the assembly from voting a motion of censure. As Sir Percival explained:

"We have a right to expect [illegible] acronyms from the [illegible] bureaucracy because it is so highly developed, it is not some third-world bureaucratic power. We expect a lot, and when we see amateur groups like the marijuana lobbyists coming up with lovely acronyms like NORML (National Organization to Reform Marijuana Laws) and we see the bureaucracy coming up with ugly acronyms like SAODAP, ADAMHA, and DNADA, then we feel they must be called to account before the bar of the world opinion."

(Wayne Howell is an Ottawa physician and freelance writer.)

Drugs, prostitution linked: COYOTE



Margo St James

'Drugs and prostitution have to be decriminalized at the same time to get the hooker off the streets . . .'

PHOENIX — A female drug addict will likely become a prostitute to support her habit, according to Margo St James, a "retired" prostitute, and founder of COYOTE (Call Off Your Old Tired Ethics).

Ms St James, a leader in the move to decriminalize prostitution in the United States, told the 1st International Action Conference on Substance Abuse here: "Drugs and prostitution have to be decriminalized at the same time in order to get the 'hooker' off the streets." (COYOTE, a prostitute's guild, has been fighting for decriminalization of prostitution since 1973).

Ms St James said complaints about prostitution stem from its visibility, and the majority of prostitutes "walking the block" are those who are hooked on drugs — mainly heroin.

"An addict-prostitute will be out on the street, stopping cars, waving, and not being careful about whom she chooses as a customer. She is arrested much more frequently than a 'professionalized prostitute' and she doesn't care about her clothes or her looks.

"If we don't decriminalize drugs and prostitution at the same time, the streetwalker will still be out there, trying to get to the customer the fastest way possible. She wants to avoid the waiting that a 'call girl' or 'parlor worker' has to do."

Ms St James said in some areas of New York City, up to 90% of the prostitutes on the streets are hooked on drugs, but in other cities, such as San Francisco, the percentage of addict-prostitutes is "fairly low" — between 20% and 35%.

Police are reluctant to see prostitution decriminalized, she said, because it will "shut down their informant network".

"They (police) bust junkie-prostitutes, get them on probation, and turn them into informants. The women are forced to flirt, and forced to give information to the cops about what's going on in the drug scene in the streets."

Police claim also, Ms St James said, that there is a lot of crime associated with prostitution: "But why is that? These women who are addicted and into prostitution are not into prostitution for sex. They don't like sex for the most part and that's probably why they're junkies. It makes it easier for them to work if they take drugs. It lessens the reality for them."

She said many women become prostitutes because their boyfriends are using drugs. They turn to prostitution to support their boyfriends' habits, and end up becoming addicted to drugs themselves.

"It's your femaleness that you capitalize on, whether you sell 'dope', whether you sell sex, or act as a receptionist in some company's front office.

"Women who are dependent emotionally on men — their 'pimps' — tend to be strung out emotionally on drugs as well. They are a dependent-type person, whereas a 'free-lancer', a prostitute who's working to better her lifestyle, is going to go against everything she's working for, by taking drugs."

Ms St James said 'speed' is now becoming the drug of choice for many prostitutes, "because then she can stay up longer, work longer, and be wittier."

"Marijuana, heroin, and speed are the three main drugs used by prostitutes. I don't know of too many alcoholic prostitutes.

"Women who are professionalized prostitutes are not going to get into 'junk', although every prostitute I know smokes pot. What usually happens is that women are junkies first, and prostitutes second."

She concluded: "I have never had a case where the woman was a junkie prostitute, cleaned up her addiction, and continued being a prostitute."

Treating early alcoholism

Doctors must see pitfalls

WASHINGTON — The family physician is situated ideally to treat a patient with an early drinking problem but there are pitfalls if he is not prepared.

"The question is not should the private physician treat the alcoholic, but under what circumstances?" according to Dr Benjamin Kissin, State University of New York, Downstate Medical Center.

He told the national conference on medical education in alcohol and substance abuse here many alcoholics can be frustrating in their behavior, which includes a laxity in paying medical fees.

"It is a cruel and harsh thing to say, but I think the family physician is better off not treating that kind of patient, because he is just going to lower his own tolerance for other alcoholic patients, and he is not going to be a success with that kind of patient," Dr Kissin said.

The family physician takes on a tremendous responsibility and must be aware, and sure, of what he/she says and how he/she says it.

Dr Kissin explained: "If you have a self-destructive patient who is out to kill himself with alcohol, telling him his heavy drinking is killing him is just what he wants to hear; and he is going to drink more heavily.

"Family physicians and internists must learn their own limitations, and what treatment can work, and what can be disasterous."

Dr Kissin said the ideal is to have the family physician treat the socially stable, physicially well patient who is in the early stages of alcoholism, and with a family intact.

"Where physicians do learn to have a family responsibility, and relate to the wife and children, they might be a truly effective means of primary and secondary prevention as well," Dr Kissin said.

"The family physician is the first to see alcoholism develop in the early stages, and could contribute in a major way to early detection and treatment."

Drink ad restrictions under scrutiny

TORONTO — A restriction on the number and size of advertisements a brewery or distillery may place in a publication is being considered by Ontario's consumer and commercial relations minister.

Larry Grossman said in the Ontario legislature last month, these restrictions are "under careful consideration. We may be bringing them forward in the near future."

Mr Grossman said the proposal is "within the context" of the government's intention to present a package of legislation in the spring session that would, among other things, raise the drinking age to 19 or 20, from 18 years of age. (**The Journal**, Dec 77).

"Either there will be something forthcoming in the near future on this specific subject, or it will be part of our spring package . . .

"All I can do is tell the liquor companies to restrict their advertising to a quarter of a page, half a page, or a whole page, or whatever, in a particular issue," Mr Grossman said outside the House.

He said his ministry has not done a formal study of the relationship between the amount of liquor advertising in publications, and the drinking habits of readers.



Larry Grossman

'Lifestyle' annoys

TORONTO — The good life annoys most Ontario residents — at least as it's portrayed in liquor and beer "lifestyle" advertisements.

Lifestyle advertisements should be cut back or discontinued, a sample of Ontario residents said in response to a survey conducted by the Canadian Institute of Public Opinion.

Thirty-eight percent of 1,059 people want the advertisements discontinued, and 35% want fewer advertisements. A substantial number (21%) were undecided and 5% want more such advertising.

Eastern Ontario (48%) was most likely to favor the discontinuation of lifestyle ads, while the more rural northern Ontario was most in favor of fewer advertisements (40%). In metropolitan Toronto and outskirts combined, the responses were 30% for fewer advertisements, 33% for discontinuation, and the balance undecided.

Scotland launches campaign

EDINBURGH — A further major public education campaign has been launched in Scotland — following a similar campaign last year — in an attempt to reduce the country's appalling alcohol problem.

This time the target is Scotland's 20 to 30 year age group which is now recognized as being especially at risk.

A spokesman for the Scottish Health Education Unit, which is responsible for the initiative, told **The Journal** that during 1976, the unit received more than 700 letters from Scots seeking urgent help for their drinking problems. Of these, 260 were offered expert counselling.

The SHEU estimated 75,000 Scots (2% of the adult population) drink to excess, and a third of these are physically dependent on the drug. Scottish children know soon about the special significance of alcohol and by age eight have already usually had first-hand experience of drinking, either in the street or at home.

Admissions to Scotland's psychiatric units for alcoholism doubled between 1965 and 1975 (from 2,736 to 5,438 men and women), and drunkenness offences rose by 35% during the same decade, (four times higher than the rest of the UK).

Ex-smoker, ex-drinker points out

Ambivalence rife in addictions field

WASHINGTON — A righteousness exists about cigarette addiction which is often missing when it comes to alcohol, believes LeClair Bissell of Roosevelt Hospital, Columbia University.

While any hint of prohibition towards alcohol rouses intense feelings, "nobody seems to get lumped up about the idea of prohibiting cigarettes," Dr Bissell said at the national conference on medical education in alcohol and drug abuse here.

The righteousness of some fellow ex-smokers she finds most irritating. "They do not apologize for one minute for making life miserable for people who still smoke, crowding them in the back of airplanes, or sealing them off in restaurants."

Such restrictions in terms of alcohol would never be tolerated.

Dr Bissell said: "We have all these interesting debates going on whether we should, or should not, have a return to social drinking as the goal for the alcoholic.

"That might be to me more consistent if we had more people trying to get us ex-smokers back to social smoking."

As a recovering alcoholic for 24 years, she cannot count the times she has been crowded "by people who were bound and determined I was going to go back to social drinking, to prove one theory or another.

"But since I have stopped smoking three years ago, virtually nobody has been pushing on me to have two cigarettes after dinner. And I am curious, why not? I don't think two cigarette are going to influence my thinking or judgement."

Liquor store ban rejected

YELLOWKNIFE — Inuvik residents have voted to keep their community liquor store open.

An unusually high 71% of the community's eligible voters — 948 of 1,335 people — cast ballots in a plebiscite at the town's Family Hall.

The plebiscite attracted more voters than the last municipal election in that town, when only 24% of the voters turned out at the polls.

Some 319 people — 34% — favored closing the store to all over-the-counter sales while 627 people — 66% — didn't want the change.

A simple majority vote is required to close a liquor outlet in the Northwest Territories.

A change in the liquor laws in the NWT has made it possible for each settlement to establish its own liquor policy. Inuvik's response to keeping their community "wet" is contrary to that of numerous other NWT communities in which inhabitants have voted to make it an offence to have liquor anywhere, at any time. (See **The Journal**, April, 1977).

Rae Edzo, near Yellowknife, is one example of such prohibition of alcohol. In Frobisher Bay on Baffin Island, a petition from 300 citizens prompted the closing of the government-run liquor store.

Heroin use up in NZ

AUCKLAND, NZ — New Zealand drug users and dealers are increasingly moving to heroin.

Heroin prosecutions numbered six in 1973. The 1977 tally is expected to top 150.

Pure cocaine 'proves devastating': Nils Noya

LA PAZ, BOLIVIA — Brain damage, which appears to be irreversible, is being found among Bolivians addicted to smoking cocaine paste or inhaling a nearly pure form of the drug.

Nils Noya, director of the Bolivian National Institute for Investigation of Drug Dependence, has documented some 500 people suffering these effects. He estimates there are at least 3,000 more addicts still undetected.

Dr Noya says: "We are trying to do our research as honestly as we can, and not put forward a theory that will prove invalid eventually.

"But what we have found in people, even two or three years after they have stopped using cocaine, is devastating.

"Within a short period of time, at the most six months after they start smoking cocaine paste, or inhaling pure cocaine at least four times a week, they have lost control of their intellectual powers or possibilities.

"They are dead intellectually. Their deductive reasoning powers have been abolished. Even a simple mathematical problem upsets them."

This is coupled with extreme severe effects from withdrawal, Dr Noya continues.

"They suffer from depression, and cocaine paranoid psychoses with hallucinations and delusions. They retain these paranoid ideas and they are very aggressive."

The addicts suffer also from "terrible formication," a sense of small insects crawling on the skin. Most have severe scars caused by scratching.

Dr Noya adds: "Our theory, from what we have seen so far, is that cocaine attacks directly the cells in the brain, especially the alpha cells. We think the intracellular glucose is extracted by the cocaine.

"We think too, that, unfortunately, the damage is irreversible. We have, for example, given addicts high doses of glucose, but that has not proved successful."

Cocaine addiction in Bolivia has appeared only within the past five years. Until then, hard drug use was rare. Dr Noya has yet to hear of a single case of heroin addiction in the country.

Dr Noya emphasizes the strength of cocaine used in Bolivia is quite different from that found so far in North America.

'We are trying to do our research as honestly as we can . . .'

"I talked to some American research colleagues recently and they are using cocaine in their experiments that is 10% pure. Here that would be like using laughing gas (nitrous oxide).

Cocaine addiction in Bolivia is divided geographically. In the jungle city of Santa Cruz, the centre for illegal cocaine production, addicts smoke cocaine sulfate paste mixed with tobacco.

In La Paz, high in the Andes, addicts inhale cocaine hydrochloride powder which is 97% pure.

Until recently, around Santa Cruz, leaves from the coca plant were packed into large oil drums and the alkoloid extracted by kerosene and other ingredients. But there is now an even cheaper method.



Nils Noya

Dr Noya explains: "They rot the leaves down with water and use sulfuric acid to extract the paste. It takes longer, but it is cheaper."

The crude and adulterated cocaine paste sells in Santa Cruz for 200 pesos ($8) for a full matchbox. The matchboxes used are from Brazil because they are slightly deeper and wider than those produced in Bolivia.

But then, national pride takes over. The addicts insist on mixing the paste with tobacco from a popular Bolivian brand of cigarette, Darby, into what they then call *papilloes*. One matchbox of paste yields 200 *papilloes*.

The addicts sit around in groups and puff the *papilloes*.

Dr Noya: "Immediately after smoking a cigarette they have diarrhea. I mean immediately. But the worst part is that they have to go on smoking and smoking until they finish the box."

Ironically, most addicts are also producers, "and their life is devoted entirely to cocaine. Most of the paste made around Santa Cruz is produced by the addicts. It is a vicious circle."

Cocaine paste is purified into the white powder cocaine hydrochloride. In La Paz, the powder, now 97% pure, is sold for an average of $3,000 to $5,000 a kilogram.

It can be bought quite easily in the Indian quarter of the city, although the descendants of the Incas do not use cocaine itself, but chew the coca leaf.

An addict who smokes paste does not inhale the powder as well: "When you have one form you do not need the other," Dr Noya says.

"More cocaine paste has to be smoked to get the effect of cocaine hydrochloride, and the reaction is not so strong. However, because the paste is so adulterated, it is more toxic, and produces more brain damage than cocaine hydrochloride."

Dr Noya is frank: "If you were to inhale pure cocaine only once or twice a month, in truth it won't hurt you. But we are tying to make people understand cocaine is a hard drug and extremely difficult to handle."

Most of the addicts say smoking or inhalation first produces a general sense of euphoria: "They feel they are masters of the world, can solve any problem, and they are brilliant intellectually. In some cases, but very few, they say their sexual performance is improved."

Most of the addicts have tachycardia (very rapid pulse rate) and flushing for about 20 minutes.

Whether to paste or powder, the addicts become addicted completely within a few months, and all of their time is spent in finding a new supply. One of Dr Noya's patients in La Paz was inhaling 25 grams of cocaine a day.

Within a few days of ending cocaine use, acute side effects set in — depression, paranoid psychoses, hallucinations, and aggression.

Dr Noya finds the ex-addicts "become very dependent on you and they really do need tender loving care. They are always suspicious and aggressively on the defensive."

'A person who becomes a cocaine addict cannot live normally again. . .'

Some former addicts have suffered less loss of intellectual powers and had milder side effects than the majority. This is one facet of the problem Dr Noya is now researching.

A major problem in research is that most addicts will not voluntarily enter Dr Noya's government-run institute for treatment. Most of those treated by Dr Noya and his colleagues went to private doctors before being referred to the institute.

His institute is now setting up a research program for 100 addicts "in which we can give them good care and follow-up for one, two, or even five years."

Until long-term research proves otherwise, Dr Noya concludes: "We have to face the fact that cocaine is a hard drug. It can collapse you as a human being.

"From what we have seen, a person who becomes a cocaine addict cannot live normally again."



Harvey McConnell, The Journal's contributing editor, Washington, DC, reports from Boliva, Peru, and Colombia. More next month.

Latin nations seek uniform treaties

LIMA, PERU — A uniform treaty for the extradition of drug traffickers among South American countries will be hammered out here at the end of January by the respective attorney-generals.

This follows a preliminary meeting in Quito, Ecuador, last fall, at which representatives of the various nations agreed a uniform treaty is now necessary because of the vast scale of illegal drug trafficking.

Peruvian Attorney-General Nelson Diaz Pomar says the conference will also consider a model law that countries can adopt to deal with traffickers. Each country is working on its own version of the law, and advice is being provided by the United States department of state.

Doctor Pomar says: "I think this is a very important step for all of us. Already, Peru has signed a treaty with Bolivia, Argentina, and Brazil, and we plan to sign a treaty with Ecuador and Colombia so we can all work together in fighting the drug traffic."

At the same time, a request to the United States to provide a special training course for Peruvian magistrates so they can learn how to deal effectively in drug trafficking cases, has been made by Dr Pomar.

Until quite recently, most magistrates had not had to deal at all with trafficking cases. However, since Peru has become a major source of illegal cocaine in the past three years, the number of cases, in Lima especially, has burgeoned.

Dr Pomar says: "In 1974, we had 250 trafficking cases in Lima; today the figure stands at 1,500, and the number of defendants involved in each case can range from three or four up to 20."

The Peruvian judicial system is based on the Code Napoleon, inherited from Spain. Under it, magistrates are in charge of the entire investigation while defendants are in custody.

"We feel our magistrates need this special training because everything in the drug trafficking area is so new to them. We think also the Anglo-American system of justice is more practical and less complicated than our own in such cases," Dr Pomar adds.

"It is important to know the experiences in other countries, and from them we can apply the things which are good for our country."

Hundreds of millions of dollars are involved

Only traffickers get rich on Colombian drugs

BOGOTA, COLOMBIA — Hundreds of millions — if not billions — of dollars are involved in the current illegal trafficking of marijuana and cocaine from Colombia to North America and Europe.

This is the estimate of an extremely well-informed Colombian observer in a country which is not only wrestling with drug trafficking but unemployment, inflation, and urban terrorism.

The observer points out: "This is a democratic country, after all. We have presidential elections this year, and there are many honest government officials, policemen, and judges who are tying to do their best.

"At the same time, many Colombians are waking up to the fact this country has acquired a really bad reputation in the world because of drug trafficking."

It is popular in both North and South America to suggest that "the mafia" runs the areas of Colombia where marijuana is grown, and the illegal laboratories there that convert cocaine paste from Peru and Bolivia into cocaine powder. This is not so.

"Most of the money for drugs coming into Colombia is without doubt provided by criminals in North America," the observer says. "But the business here is controlled completely by Colombian criminals.

"The money is kept in a few hands. Farmers who take out their coffee bushes to plant marijuana are not making that much more money. It is only those who control the traffic who really make the money."

'There are many honest government officials, policemen, and judges. . .'

Some parts of the country, notably the Guajira district, are as lawless as the Sierra Madre region of Mexico, the centre of drug trafficking there.

A judge in one city who was about to hand down a verdict on cocaine smugglers — the evidence was quite conclusive — was shot and killed in the streets.

However, violence in Colombia is not confined to people dealing in drugs or with drug traffickers.

Bogota has acquired a reputation, both residents and foreigners living here agree, as a very dangerous city. Crime ranges from purse and watch-snatching in the streets, to murder.

In their efforts to get guns, urban terrorists have a favorite target — policemen. In the past year, 35 Bogota policemen, an average of one every 10 days, has been assassinated for his gun.

All of these factors put an enormous pressure on the person who succeeds President Alfonso Lopes Michelsen. Both the Conservative Party candidate, Bellisario Betancur Cuartas, and the four Liberal Party contenders for the nomination (the nominee will be chosen in February) have vowed to enforce the country's narcotics laws.

It is this new administration that will determine the country's course, in more ways than one.

The observer notes: "I think Colombia is right now on the brink. Unless the new administration comes down hard on drug trafficking, we might go over."

Chinese heroin supply is on increase in UK

By Alan Massam

LONDON — Increasing evidence is emerging to suggest Britain, like Continental Europe, is experiencing the impact of more and more Chinese heroin on the illicit drug scene.

A private survey by the *Daily Telegraph* newspaper suggested at the end of November that despite the relatively stable number of registered heroin addicts known to the Home Office, actual use of the drug had gone up eightfold since the beginning of 1975.

An unnamed senior police officer was quoted in the newspaper's report as saying: "It's high time the government woke up to what is going on, and that we and other involved people were given some idea of what we are up against."

Jasper Woodcock, director of the Institute for the Study of Drug Dependence, backed the newspaper by demanding two national surveys of heroin misuse in two consecutive years, to establish a pattern. "The means of carrying out such heroin surveys are straightforward enough. All we need is the money — a mere total of about £10,000," he said.

Mr Woodcock told **The Journal** the Home Office (the department of government concerned with home affairs) had reported some 1,000 hard drug addicts had removed their names from the registration list of those receiving heroin by prescription (as they may do from government-controlled clinics in this country) during the last 12 months.

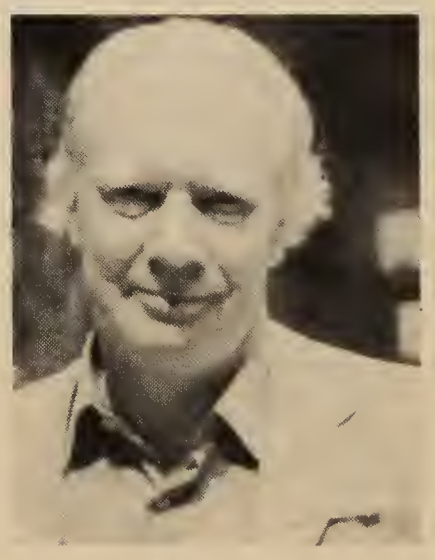
"But no one is suggesting they were suddenly cured," he said.

Many were probably rejecting the methadone given for maintenance by the government drug clinics in favor of the new supplies of Chinese heroin entering Britain through London and Liverpool.

Most observers are expecting the 1977 figure for deaths from heroin addiction in England and Wales will show a sharp rise compared to the previous year. This will reflect the recent pattern in Continental Europe where heroin addiction figures are thought by British officials to be alarming.

The *Daily Telegraph* said the estimated eightfold increase in the use of heroin was based on seizures of illicit heroin in Britain by police and customs officers. In 1975, the figure was 14 lb; in 1976, 46 lb, and by August 1977, customs officers alone had seized 64.35 lb of heroin.

The total with police seizures for the year is expected to be well over 100 lb. Drug enforcement officers here believe that for every pound of heroin confiscated, 10 more get through.



Jasper Woodcock

Ramon Adame:

'We are waifs of health care delivery'

By Karin Pargas

PHOENIX — The substance abuse field is the "illegitimate child" of health care delivery in the United States, and unless it can make inroads into government bureaucracy, this lack of acceptance will continue.

Ramon Adame, president of the Chicano Alliance of Drug Abuse Programs in the US, a now-recovered heroin addict of 22 years, said here the drug abuse field originated from a response of fear to the "drug abuse menace" in the country.

Efforts by substance abuse workers to combat the drug problem were "self-created treatment processes", he told the 1st International Action Conference on Substance Abuse.

"We began something that has had an impact on the problem, but is somewhat different in approach from what exists in the accepted professional field — a 'medical model'. We therefore created suspicion in the minds of others in the health care field from our specific emotional and experience perceptions of how to deal with this problem."

Mr Adame said that given enough time, the "track record" of substance abuse workers would give others in the health field a "reality from which they could accept us as legitimate associates.

"The problem is that maybe we didn't get enough time for this to happen. I believe we began to realize this when we found that funds were tied to criteria based on the medical model."

Mr Adame said he perceives membership in the health field as being tied to a formula of education, theory, and process. But, he added, many substance abuse workers have picked up their education from the "University of the Street", with its own vocabulary and theory — a process based on experience.

The government bureaucracy must recognize this treatment based on experience "because it has been proven to work.

"My personal experience may only work for me if other people share it. I realize that processes are only 'vehicles', not ends in themselves, but when many people share similar processes then I say we have a good vehicle to get us where we want to go.

"The professionals in health care have changed to newer theories and processes as the years have passed . . . So, if the professionals change to a better vehicle that reflects the times, and works with certain people, and we in drug abuse share a vehicle that works for us with certain people, why does the professional vehicle have more credibility and funds than ours?"

Drug abuse workers must sell their programs based on their experience "so that we don't have to give up what we have just to get funded," he said.

"I am not asking for other vehicles of health care delivery to be disregarded. I am asking that our own 'psychology of health' be accepted as equally valid."

He said Congress must recognize the unique needs of the substance abuse field "so they can decide to provide realistic support to us, and believe in us."

The alternative, he added, is just to build new prisons, and place more narcotic offenders in jails.

"Congress, the department of labor, other departments in health, education and welfare, and the department of justice need to know what we are about if we are to continue developing in this field.

"The National Institute on Drug Abuse, it seems, is our only associate in this bureaucracy, and their associates in the bureaucracy seem to be the obstacles to overcome in our future. We must realize NIDA has limitations, and forward our efforts to the other federal agencies that are reluctant partners to our future survival in health care."

Pride paramount

PHOENIX — Ramon Adame, who calls himself the "biggest Chicano ex-addict" in the United States, says rehabilitation of drug-dependent Mexican-Americans can only be achieved through a one-to-one trusting relationship with their counsellors.

Mr Adame, president of the Chicano Alliance of Drug Abuse Programs in the US, told the Ist International Action Conference on Substance Abuse here: "A Chicano can't expose his personal problems in a group setting such as a therapeutic community. The only treatment he will accept is when he trusts his therapist enough to break down and cry — something he won't do even in front of his family."

He said many Chicano clients feel threatened in a treatment setting because they don't know what to expect from their counsellors — whether they will act as prosecutors, or people who show off their superior knowledge, therefore creating a negative bias on the part of the client.

"I will never forget where I came from — the jungle of the streets, and it is important, when treating Chicanos, not to take away the survival skills they have learned in their barrios."

These survival skills can be molded in a positive way, he said, so an addict can be rehabilitated.

"The Chicano is a person with pride and stoic presence. Any interaction with a Chicano must take this into account. Survival and ways of being are built, to a large extent, on these elements.

"An addict has a sixth sense in bringing out phonies, because that's a survival skill they've acquired. They're psychologists in their own way, and can size up a counsellor quickly to see how sincere he is."

Mr Adame said one of the main problems facing counsellors treating Chicano addicts is that "they can't understand that a client won't act as a recipient of our intellectuality. Rather than coming down to his level of understanding, we expect the client to come up to our level."

A Chicano trusts no one — except, perhaps, his priest: "The only person we semi-trust is a priest, and we only tell him 50% in our confessions because we don't want him to think that we are that bad," Mr Adame commented.



Ramon Adame

Building a good self-image is vital for women drinkers

PHOENIX — A positive self-image is crucial for the recovering woman alcoholic if she is to maintain sobriety, Jean Kirkpatrick, founder of Women for Sobriety told the 1st International Action Conference on Substance Abuse here.

Dr Kirkpatrick said unless counsellors deal with the emotional needs of a woman alcoholic, her sobriety will be a limited period of "hanging on by her fingernails, trying to get through each day without touching alcohol.

"If a woman alcoholic's problems with depression, guilt, and low, or no self-esteem are not dealt with in treatment, then you will have a woman who is caught in a revolving door of drinking and not drinking."

Dr Kirkpatrick said while alcohol affects both the male and female similarly on a physiologic basis, the emotional needs and problems of a woman alcoholic are different from those of a male.

"Women feel as second-class citizens. They have been seen as the help-mate of the male, a paragon of purity, the mother of the race, and the one who can do no ill. Consequently, when society sees a woman as alcoholic, she is cast into the role of a fallen woman — one who is to be disgraced, neglected, and negated.

"No matter how much we talk about the fact the stigma of female alcoholism is being alleviated, . . . in 100 years from now, it will still be there. When a woman is caught up in the addictive process, there is not much help available to her. Yet if her husband has a problem with alcohol, his job pressures are blamed for his addiction and his company may likely help him through his treatment."

Dr Kirkpatrick called the lack of available treatment facilities for alcoholic women in the United States "appalling".

"Just look at the 600 halfway houses in the US, only 30 of which are for women. Look at the fact the US government spent $75 million dollars on alcoholism programs in 1976, and only $2.5 million was for women. And yet it is the woman alcoholic who most desperately needs more care than the male alcoholic."

She said a male has usually a supportive family group to help him learn to cope as a recovered alcoholic, but when a woman comes out of treatment, she rarely has a family left.



Jean Kirkpatrick

"The woman alcoholic is usually in the process of separation or divorce, she has most frequently lost the custody of her children; so she not only has her alcoholism and sobriety to deal with, she's got loneliness, alienation, separation, and a whole host of additional emotional problems that a male alcoholic does not usually have."

Dr Kirkpatrick said the fact the woman alcoholic does have additional problems must be taken into account in her treatment, and for it to be successful, treatment will probably take more time, be more in-depth, and include after-care.

She said while she is not against Alcoholics Anonymous programs to provide this after-care, she believes women alcoholics need special help through programs that give them positive enforcement and reinforcement.

"We don't spend time talking about how, when, and where we started to drink. We talk about how we can project images that are positive, about living here and now, and where we go today and tomorrow."

Dr Kirkpatrick added: "Women for Sobriety provides an additional program to AA. Because AA was so successful since its founding more than 40 years ago, we thought we didn't need something more. That was just an assumption that was made, and from the response to the Women for Sobriety program, we now know that was a false assumption."

EDITOR
Anne MacLennan

STAFF WRITER/PRODUCTION EDITOR
Karin Pargas

CONTRIBUTING EDITORS
Harvey McConnell (Washington)
John Shaughnessy (Toronto)

SCIENCE EDITOR
Dr Ruth Segal

The Journal
Published by Addiction Research Foundation of Ontario
33 Russell St, Toronto, (416) 595-6053

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Editor... Letters to the Editor... Letters to the Editor...

Wayne Howell shocks and dismays me!

I have been a subscriber for many years and am completely shocked, dismayed, and surprised that **The Journa**l would permit a scurrilous attack by Wayne Howell on the expertise that is rampant in the field of alcoholism. Obviously, the fact that he is a physician and a freelance writer disqualifies him from even being listened to, much less printed.

I happen to have devised a treatment program for the cure of the problem of alcoholism that is guaranteed to be 90% to 95% effective and costs a mere $7,500 per patient financed normally by a second mortgage on the patient's $75,000 to $100,000 home at a rate payable that he can afford. This eliminates health insurance problems and a whole bunch of governmental funding.



A note to Wayne Howell

The program is simple: We divest the patient from his environment, impound him in a 30-day program, and require him to stand on his head in the corner for two hours a day, reading the Lord's Prayer backwards in Sanskrit. At the end of such time, we then require him to play volleyball for two hours, do pushups for another two hours, and then place him in front of a television set with the instructions that he is to contemplate his navel until he gets tired enough to go to bed.

At this time, the profile of those whom we admit to our program is as follows: (1) He has to be white; (2) he has to earn $37,000 to $45,000 a year on a job in which he has upward mobility; (3) his mortgage payment on his $75,000 to $100,000 home can be no more than one payment behind, and his two newer-model automobiles are in good shape; (4) his two to five well-adjusted and happy children have turned down the opportunity to go to private schools.

This model works, and notice that it makes no distinction between whether the person is sick in the head or sick in the gut.

Our alternate program is called The Burlap Bag Theory of Alcoholism Treatment, that being: take any random 100 so-called self-defined, or defined by some wise expert in the social delivery system (alcoholic), and shake them in a burlap sack for 30 days and then pour them out. At the end of two years, it has been our prediction that 27 to 30 of them will be sober, which from our statistical examination approximates that of any other treatment program yet devised other than our Sanskrit, volleyball therapy program. This second and cheapie program also doesn't require experts; national, state, or local funding; or PhDs and other self-appointed and/or anointed gurus, and notice again that we care not one whit whether or not alcoholism is a disease.

Alva C. Long
Attorney
Auburn, Washington 98002

'A smokescreening of the facts'

A request for information from one of your readers revealed that **The Journal** (Sept, 77) reported inaccurately that William F. Dwyer of The Tobacco Institute spoke at the annual meeting of the American Lung Association last May in San Francisco.

Mr Dwyer did not speak before the meeting of our organization. The Tobacco Institute called a press conference in San Francisco last May 16 to attack the American Lung Association for its smoking and health positions. The press conference is part of a continuing attempt by The Tobacco Institute to cast a smokescreen over the changes in attitude of the American public toward cigarette smoking, the increasing percentage of adult non-smokers, and the growing willingness of non-smokers to speak up for their rights to breathe clean air.

Since the publication in 1964 of the first of eight smoking and health research reports by the US Surgeon General, and the public education campaigns of the American Lung Association and its sister health agencies, the number of adult Americans who are non-smokers has increased by 22.4 million. During the same period, the number of cigarette smokers declined by 2.8 million. The percentage of adult men who smoke dropped from 52.4 to 39.3; the percentage of adult women smokers from 32.5 to 28.9.

Nine of 10 smokers say they would like to give up cigarettes. Fifty-one percent of smokers think smoking should be limited in more public places. Seventy-nine percent of smokers consider smoking a health hazard requiring action.

The cigarette sales curve is leveling, with increases of less than 1% for the past two years. Per capita consumption has declined steadily during the 1970's. (Per capita consumption peaked in 1963, the year before the Surgeon General's report was issued.)

Helen Jones
Director, Public Relations
American Lung Association
New York, NY 10019



How pleased we are

We are very pleased with the article, Prevention program tailored for native people (**The Journal**, Nov 1977) and would like, personally, to send our thanks to Linda Matchan for taking the time to investigate and accurately represent the program in your publication. I appreciate the opportunity you have given us to share our program with others in the prevention area across Canada.

Pat Koperno
Prevention Development Officer
Education Programs
Alcoholism Foundation of Manitoba
Winnipeg

Too much about pot

We are a treatment centre for persons with alcoholism.

In your paper, much of your space was devoted to the legal questions concerned with the use of marijuana. Frankly, I know all the arguments for and against the use of marijuana and prefer a wider base of information, such as is provided in other publications.

Tom Brink
Assistant Administrator
Fairbanks Hospital, Inc.
Indianapolis, Indiana 46202

Standards stay high

Please accept my congratulations for the continued high standard of your publication, and we appreciate the opportunity to use your material in *The Australian Temperance Advocate*.

The articles by Wayne Howell are gems, and I would hope they may be published in booklet or individual brochure form at some stage.

Arthur Harwood
General Secretary and Editor
The Australian Temperance Advocate
Brisbane, Australia

TJ cartoons on TV?

I do wish some of your cartoons could be shown on television to show the other side of the happy alcohol drinker.

I find **The Journal** of interest to me as a nurse, even though I am now retired at age 82.

I have passed some editions to relatives, and have also given some editions to my minister.

Frances Nancekievill, RN
Cannington, Ontario

Addiction Research Foundation of Ontario
World Health Organization Collaborating Centre
For Research And Training
On Drug Dependence

The ARF — WHO International Seminar, Toronto, November, 1977

Anne MacLennan reports for:

The Journal

India: scale of potential need is staggering

THE HIGHLY professionalized approach of developed countries to drug dependence programs cannot work in developing nations, says the chief of psychiatry at one of India's most respected medical schools.

And even to discuss implementing western models in developing countries is probably irrelevant, Narendra N. Wig said.

"It may sound harsh but there is no escape for us when we look at what you have organized and the way you have highly professionalized your services and programs. This is not a practical proposition at all for us.

"Developing countries have to develop models which can be brought down to the ordinary village worker. We have to evolve new models, de-professionalize. We have to simplify the technology, bring it down to a very elementary level, and make it part of the larger general health service."

Dr Wig, of the Post Graduate Institute of Medical Education Research, Chandigarh, India, said he was "very uneasy" about being a discussant in the control strategies section of the seminar.

"A few years ago, we thought drug dependence was not our problem but a problem of the developed world. We have become aware this is a serious problem in developing countries, a rapidly growing problem.

"But, when in developing countries we sit down and try to examine our resources and how much will be necessary, we are completely appalled by the magnitude of the problem.

"India has a population of more than 600 million people. That means roughly one of every seven people in the world, on this planet, lives in India. When I think of the resources available, and the health services and the magnitude of the problem, you can get a rough idea of the relevance of what is going on (here).

"When a person with an alcohol or drug problem comes in for treatment in Toronto or New York or London, how many thousands of dollars have been spent on that particular person? When I see your figures and very proudly you tell me that you're able to rehabilitate about 15% or 20% or something of this magnitude, and the bill runs into God knows how many millions of dollars annually in a particular centre or budget, obviously this is not the model for us."

"So what are we going to do? I honestly don't know. But one or two things are uppermost in my mind when I think of the problem.

"The models which currently exist of control and of management are not satisfactory and not practicable in developing countries.

"In developing countries, drug dependence cannot be isolated from the total health and total social problems and should and must remain part of the total program.

"Drug dependence, to my mind, offers us a remarkable opportunity to develop models for psychosocial change which can be applied in many other areas of human life and development in developing countries."

Dr Wig is an overseas corresponding member of **The Journal**'s editorial board.

Canada invites requests for financial aid

SENATOR KEITH Davey has invited developing countries where opium poppies are grown to come to Canada for direct assistance in controlling the problem.

Senator Davey referred to the $1.2 million Canada has contributed over six years to the United Nations Fund for Drug Abuse Control.

"The assistance provided by the fund, however, is only seed money, both in the international organizations and in the countries to which direct aid is given.

"For example, in the case of crop replacement, only pilot projects are being carried out in the countries where the illicit production of the opium poppy occurs. After crop replacement has been shown to be successful, it is then hoped that countries concerned will use their own resources to continue and enlarge the project. In particular, they are expected to ask for help from international assistance programs and bilateral aid agencies in combatting this problem at the source.

"As an aside," said Senator Davey, "may we suggest to our guests from developing countries where there is a problem with illicit poppy growing, that if your countries give high enough priority to this effort, your governments could make a request, through the Canadian Embassy in your country, to the Canadian International Development Agency for bilateral assistance to extend the work of the UN Fund for Drug Abuse Control pilot project in your country.

"These are rural development projects which fall well within the mandate of our aid agency and I am sure such appeals will get very sympathetic consideration."

Donald M. Smith, senior scientist, department of national health and welfare, called Canadian aid to developing countries "double-duty dollars."

Dr Smith told **The Journal** in an interview: "We have sinks of (drug) demand not only in North America and Western Europe, which has also become a major problem, but also among the populations of South-east Asian countries, for heroin.

"We have to help them eliminate this problem in order that we can get back to the supply situation, cut down supply. This is only effective if we reduce demand where it originates. Therefore, it's to help these countries to help themselves which, in turn, should help us.

"The point is, we're giving development aid for rural development in other parts of the world, why not give it in those places where it can also help us?

"These are, you might say, double-duty dollars. It's not only helping people in rural developments, which is definitely part of the CIDA program and also one of their priorities. But, it's helping in an area which is also going, indirectly, to help Canada and the rest of the world suffering from drug dependence problems."

Senator Davey, speaking of the "Canadians who have worked with the international health organizations over the years," said the ARF had a well-deserved reputation on the international scene already. "There are few such centres of excellence in the world."

He also suggested the establishment and recognition of ARF as a collaborating centre, is a tribute not only to an institution but also to one person.

H. David Archibald, founder of ARF and now executive vice chairman, "is a person who has devoted his efforts over many years to assisting in the international community. Not only has he acted as an advisor to the World Health Organization itself but he has been a consultant in developing countries, notably Thailand."

DuPont: 'I think it's very scary'

Global silence reigns on cannabis

ALMOST THE entire world is going through "a very fantastic change" with respect to cannabis consumption.

But almost 'nothing is being done about trying to understand the phenonenon or deal with it, says Robert DuPont, director of the United States National Institute on Drug Abuse.

"It seems to me that the smart people and the powerful people in the world are literally turning the other direction and saying nothing . . . about what the policy implications should be or anything else.

"It's as if we've all (joined) a conspiracy of silence on the subject. I think it's very scary," Dr DuPont said here.

He termed the increasing and widespread use of cannabis, "one of the most incredible changes in behavior, globally, certainly in the drug field."

Referring to increasing cannabis use around the world, he singled out Nigeria. "In Nigeria a year ago, I was struck by the fact the cultivation of cannabis is no longer a tiny operation but shows signs of becoming a major economic activity. And it's not a long step from the cultivation of cannabis to the cultivation of other drug crops."

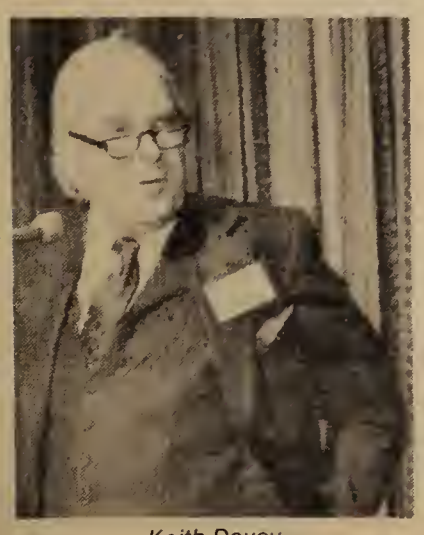
As for occasional suggestions from other speakers that one drug may come to light to replace all others, he said introduction of new drugs in populations is not generally associated with a reduction in consumption of other established ones.

"In fact, at least in the United States, where we have been seeing a very dramatic increase in the consumption of cannabis, we have not seen a reduction in the consumption of other drugs, most notably alcohol.

"And, the data suggest that people who are high users of cannabis are likely to be high users of alcohol and vice versa. In fact, if you want to identify the likely people who are going to be heavy consumers of cannabis in the US, the way to start is to find the people who are smoking cigarettes and drinking beer and watch them as they are aging and watch what happens to them because they are far more likely to use cannabis than are their peers who do not choose . . . to use those drugs.

'High users of cannabis are likely high users of alcohol . . .'

"As a matter of fact, the more heavily they are into the legitimate drugs, the far more likely they are to be involved in illegal ones.



Keith Davey

ARF is part of proposed network

THE ADDICTION Research Foundation is one of a proposed worldwide network of six World Health Organization collaborating centres for research and training on drug dependence.

Ceremonies and an international seminar commemorating ARF's designation as a WHO centre were held here at the end of November. Earlier this year, Mexico's Centro Mexicano de Estudios en Farmacodependencia, was designated a collaborating centre.

The next, according to Awni E. Arif, senior medical officer in charge of drug dependence program, division of mental health, WHO, will be the United States National Institute on Drug Abuse, headed by Robert DuPont. Only the formalities remain to be completed between WHO and NIDA, he said.

Meanwhile, three other centres are under consideration for designation — one in South-east Asia and possibly two in Europe, Dr Arif told The Journal.

Addiction Research
World Health Organization Collaborating Centre

Drugs -- an urgent international priority

Next 10 years will be rough: DuPont


Robert DuPont

THE WORLD is "in for a very rough time" in the next decade with respect to drug problems, warns Robert DuPont, director of the United States National Institute on Drug Abuse.

"And it's a matter of urgent priority for all of us to think about relatively low cost, practical ways to go about dealing with them," Dr DuPont said.

He said developing nations are in particular danger.

"I'm impressed in my travels at the unique vulnerability of developing nations to drug problems, both licit and illicit and on both the (drug) supply side and the demand side.

"And I think this needs to be taken very, very seriously whether we're talking about police forces or border controls or pharmaceutical controls or whether we're talking about treatment or prevention activity. Nations that are relatively impoverished with respect to these kinds of services are particularly vulnerable . . . to alcohol and tobacco in particular."

Pointing to Nigeria as one example, he said the role of the pharmaceutical manufacturers in terms of economic activities "would make us in the developed nations blush at the power those companies have and the impact that has on prescribing practices and the whole public attitude.

"Not that Nigeria is unique. It isn't. In fact, Nigeria is probably better situated to deal with these problems than most developing nations."

He said it is not true drug abuse is essentially a problem of developed nations.

"It is very clearly now and always has been a shared problem of humanity in developed and developing nations equally.

While there are some "very dramatic changes" going on and it would be possible to interpret these in terms of politics or economic order, "I think that would be a great mistake.

"Many of the characteristics of what we call the modern world are making a contribution to the spreading of drug using behavior. But this does not seem to me to be western in any way.

"If we look at what's happening in China, for example, with respect to tobacco consumption, or what's happening in Russia with respect to alcohol consumption, or at other countries around the world, these patterns are not related, at least not primarily or exclusively, to issues of the economic or the political order.

"They very much have to do with the fact that our citizens in all of our countries, and of whatever political persuasion or economic development, are, in fact, asserting many more choices than they ever did before and we are forcing governments into these positions because we want to make more choices for ourselves.

"With those choices come a lot of consequences that are very painful in the aggregate and for the individual. But to view this as transient or limited geographically, I think would be a terribly unfortunate way of viewing the problem."

As to why people use drugs, "there is a lot of . . . very heavy thinking about that. But I think we overlook the fact these substances are primary reinforcing agents and the biology of these substances is very clear and the number of substances that have these qualities is very substantial."

Explaining, he said: "All over the world, people will take whatever the characteristics are of their community and say we do it because of this."

In the Carribbean, people say it's so hot, they drink alcohol to deal with the sun and the heat. In Canada, they say they drink because it's so cold and dark.

"In Peru and Bolivia, perhaps they use coca leaves because they are there and not because they're cold or hungry or whatever else.

"The same thing, it seems to me, is true of opium smoking in Northern Thailand. It's not obvious to me that increasing the level of health care, or diet, or transportation will reduce opium consumption. In fact, I would suggest the evidence is exactly the contrary. That it will have absolutely no effect.

"There's perfectly good reason to improve the level of health care for Bolivian Indians, I don't question that. But, if we assume that increasing their health status will reduce their consumption of coca leaves, I think we're really asking for trouble in terms of our policy.

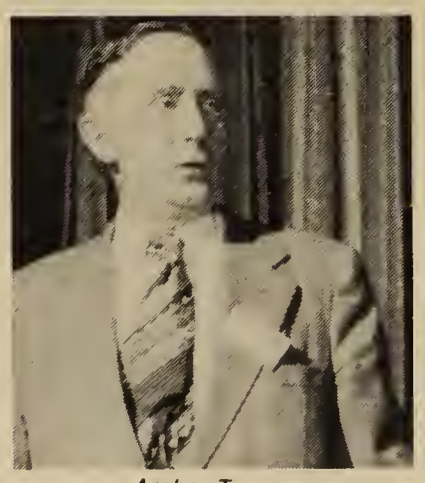
"It hasn't been obvious to me that national health care in Canada has reduced the consumption of alcohol or that it's reduced consumption of tobacco."

Helpers must recognize the ranks are serried

TWO MAJOR points must be borne in mind by countries offering sophisticated technical and professional assistance to other countries, according to Archer Tongue, director of the International Council on Alcohol and Addictions.

One point is that in providing health delivery systems and services "in the areas in which we're interested, population is a factor.

"When these people are speaking to us, I think we should see standing behind them, the serried ranks of their populations who need the services which we are not able to give as we would like."


Archer Tongue

The other point he described as more difficult but "very relevant".

"I think the impact of sophisticated technical and professional help in countries or cultures other than that from which it is being offered, and you notice here I avoid all use of 'developed' and 'developing', goes beyond the practical considerations.

"I think it is more than questions of tolerance and adaptability and understanding . . . It is that the exchange, or what we are offering, or bringing, or hope to share, has to be seen to be inherent in that culture."

To illustrate, he referred to a statement by a Sudanese psychologist, that: 'When we whip alcoholics or whip drinkers, in public, that is an aversion treatment.'

Mr Tongue said: "He is not meaning that as a defence. He is meaning that aversion treatment is inherent in Islam. It's already there. I think that crystallizes the point I want to make."

Recognizing that what is being transferred is, in some form, inherent, is an "essential element in the sharing of our resources with countries in which there is a very different cultural atmosphere, and particularly when that culture has itself achieved great heights in earlier epochs.

"The problem is to say how the know-how we wish to bring, the resources we feel we have and want to share, can be seen as an extension of, or closely related to, I would even say inherent in, the mentality which is already there.

"I feel this is extremely relevant to discussions."

Outsiders should not ignore program failures

COUNTRIES HAVE learned informally or haphazardly from each other's accomplishments but not from each other's mistakes, according to the head of Hong Kong's largest voluntary drug addiction treatment service.

"Models have been transplanted without consideration of cultural difference or manpower requirements and 'new' methods have been adopted without objective evaluations of cost and benefits," James Chien told the meeting.

Mr Chien is superintendent of social services for the Society for the Aid and Rehabilitation of Drug Addicts in Hong Kong.

"I have seen the former Public Health Service Hospital at Lexington, Kentucky, modelled extensively in the 1950s and early 60s outside of the United States for in-patient treatment; Synanon of California serving as a prototype of therapeutic communities in many parts of the world after the mid-60s; and the methadone maintenance program pioneered in New York, copied by many countries in the 70s.

"As to preventive programs, it is interesting to note that many communities started out more or less uniformly with the 'scare approach' and eventually changed to the 'information approach' at different times but finding neither approach effective eventually."

While "cheering international leadership" in drug abuse data collection and trend assessment, Mr Chien pointed to certain drawbacks and limitations in government-to-government collaboration in research.

Political considerations may affect the quality of official government reports because the authority in power may wish to present a more favorable picture than the reality as a result of a change of policy or administration, especially in the developing countries, he said.

"For example, martial law has been credited as the panacea to reduce and prevent drug abuse in some South-east Asian countries."

Sometimes, he said, there are also different opinions and conflicting interests within a government and compromised figures are reached at the expense of scientific or empirical data collection and analysis.

"Some countries which claimed to have no drug addiction problem in the past may refuse to acknowledge alcohol and non-opiate abuse as a problem worthy of reporting to the United Nations or the WHO."

He suggested private studies carried out by individual experts in different countries may be more economical, less time-consuming, and more effective.

"It may be wiser and more economical for the UN or international authorities to support such non-governmental scientific study than attempting to conduct every survey through official government channels only.

In this respect, he said the ARF-WHO affiliation was "timely".

Epidemiologists must exercise toleran

SCIENTISTS WILL have to exercise some tolerance toward circumstances in developing countries if they wish to involve such countries in epidemiological studies, an Addiction Research Foundation scientist told the seminar.

Reginald Smart, associate research director, evaluation studies, said hardware and software resources for research frequently either do not exist or are unpredictable in developing countries.

However, he added: "We should attempt to include such developing countries if we wish to 'shake-free' our hypotheses from particular local or cultural arrangements — especially those of the highly developed countries."

Among comments he made on best strategies for cross-national research were:

- studies of official records for epidemiological purposes are likely to be limited to a few developed or socialist countries and to generate data mostly about incidence and prevalence rather than broader principles;
- use of official informants will produce data or estimates from a variety of developed and developing countries. However, only limited aims can be achieved because of the rarity of data except for incidence and prevalence;
- use of Jellinek's non-official informant method seems extremely promising. It appears to be relatively inexpensive and within the capability of most countries, given some central planning and help with data collection and analysis;
- joint-development-concurrent studies are quite likely to have long term pay-off in cross-national research. Although few have been completed in the alcohol and drug area, at least they involve in-depth research which is relevant both within and across countries, striving for cross-national comparisons.

He predicted international alcohol controls will become essential in time and that international studies would then play an important role in providing the rationale and framework for

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r Research And Training On Drug Dependence

Appeals to 'social good' are fruitless

CONVINCING drinkers to stop drinking or drivers to stop using too much petrol is not unlike the problem of convincing Indians to stop having babies, says Narendra N. Wig.

In each case, people are being called upon to contribute to the "larger social good" and, in each case, they tend to remain relatively unmoved by the invitation.

"Many times my friends in this part of the world ask why can't you in India control your population? Why can't you stop producing babies?" Dr Wig told the seminar.

"I feel like telling them these social things, even in their own countries, are very difficult.

"Think, for example, of energy and resources in America. President Carter is trying to tell people not to use so much energy and again, by and large, it's very difficult not to use energy, not to use petrol. For an individual to try to do it for the larger social good is a difficult and a very complicated problem.

"When you try to tell our poor villager 'don't produce too many children because, in the larger good, if there are too many numbers, we will not be able to survive,' he sees the immediate problem that in his old age he will have no family. And this is an old age insurance: if he has more children, he will be better off, and you are not able to convince him."

The argument also holds for alcohol in terms of its acceptance in India and of responsible drinking in developed nations.

"What we're doing in developing countries is we are accepting a new kind of social order and we are accepting the western way of life and western models.

"If, in India, for example, we accept western dress, jeans, Coca-Cola, music, stereos, and tape recorders, and all that, unless there is a rejection of the value system, it would be very difficult to keep out only alcohol and accept the rest of the social things.

"So, we think okay, we'll educate our people and tell them, listen other things are good but alcohol is bad and drugs are bad.

"What we are asking is that an individual should be able to make sacrifices for the larger social good and all over the world this has been a very difficult proposition."



Narendra Wig

Alcohol educators face a mammoth task

CAMPAIGNERS AGAINST heavy alcohol use are going to have to make a commitment that will make that of anti-smoking groups pale in comparison, suggests an Addiction Research Foundation scientist.

"The health educator has been justified in making the blanket statement that smoking is dangerous to health, since the vast majority of smokers are at significant risk. Among drinkers, the vast majority are not at risk.

"The educator concerned with smoking, therefore, has the advantage over the alcohol educator of an unequivocal, easily understood message. All the same, it has taken some 25 years of campaigning to achieve the impact on the incidence of smoking which we now begin to observe.



Wolfgang Schmidt

"Clearly, a very long-term commitment will be required to make similar progress in the case of alcohol problems, and even this is unlikely to occur in the absence of legislative reinforcement."

Wolfgang Schmidt, associate director of the ARF research division and an international expert in epidemiology, particularly as it related to consumption trends, mortality and morbidity statistics, and public health costs, said mass education programs may be useful.

However, he said: "We have begun to feel an approach involving work at a more precisely targeted level is required as well."

Dr Schmidt pointed, for example, to Ontario, where a widespread effort is underway to encourage industry to adopt health-oriented policies with respect to alcoholic employees.

"Could not such efforts incorporate an attempt to have these industries develop a more comprehensive policy aiming also at primary prevention?"

Noting the appearance of alcoholic beverages in executive dining rooms and of licensed premises in many office buildings, he said: "The day may not be far off when there will be a demand to have alcoholic beverages available in the factory canteen.

"This is already the case in most high consumption countries.

"The cumulative effect of such developments may be expected to contribute to an increase in the prevalence of problem drinking employees. The widespread adoption of a broad policy respecting alcohol use within the jurisdiction of industry might help to forestall such a trend."

He suggested other large groups could also be approached in this way, including service clubs, military establishments, labor unions, and universities.

Nigeria: a when, not if issue

NIGERIA HAS so far escaped the serious alcohol and drug-related problems rampant in developed countries. The question, however, is not so much *if* the problems will come to Nigeria but *how soon*?

"We can infer future trends from the attitudes of Nigerian youth to alcohol and drug use today," Amechi Anumonye said.

"And the general impression now is there is an . . . increased tendency to use drugs among youths today. Reflecting into the future, one is tempted to ask: where are we heading?"

For the moment, use of alcohol and drugs has received relatively little official attention in Nigeria, said Dr Anumonye, professor and head of psychiatry, College of Medicine, University of Lagos.

But evidence of changing patterns is emerging, rapidly. "There is no doubt that as urbanization, industrialization, and cultural disorganization spread to the remote parts of the country, problems associated with alcohol and drug use will begin to approach those of the developed and over-developing countries.

"Our concern is how soon? Our concern is in what direction? It therefore becomes important to associate ourselves with the problem, to prepare to adapt internationally derived information and experience to the problems of Nigeria."

For now, Dr Anumonye said alcohol is being used increasingly and will "certainly become a problem of the 1980s" for several reasons:

- "the lifting of the prohibition on locally brewed gin makes for increased availability of alcohol;
- the proliferation of beer breweries within the last 10 years, apparently for political purposes, makes the dangers inevitable. Almost all states in Nigeria brew their own state beer;
- local distilling of gin and bottling of imported liquor has now received government blessing;
- gradual disappearance of the indigenous 'palm wine' from city hotels and beer parlors makes way for more potent alcoholic beverages."

As for drug use, common drugs of abuse are still not widely available and so a definite drug use pattern has not emerged. But the outlook is ominous.

"Drug abuse is no longer restricted to people from minority and poor socio-economic groups even in Nigeria. It worries lower, middle, and upper class parents. Even in Nigeria, drug abuse does not recognize socio-cultural or socio-economic boundaries.

"There is no doubt whatever, from our findings among Nigerians, that developing countries are facing the familiar drug problems because of the peculiarities of the space age generation, the alienation, and the unconventionality that goes with adolescence, which are enhanced by the communication explosion of the industrialized, urbanized, and acculturized communities."

Dr Anumonye is an overseas corresponding member of **The Journal's** editorial board.

ce abroad: Smart

establishing such controls and examining their effectiveness.

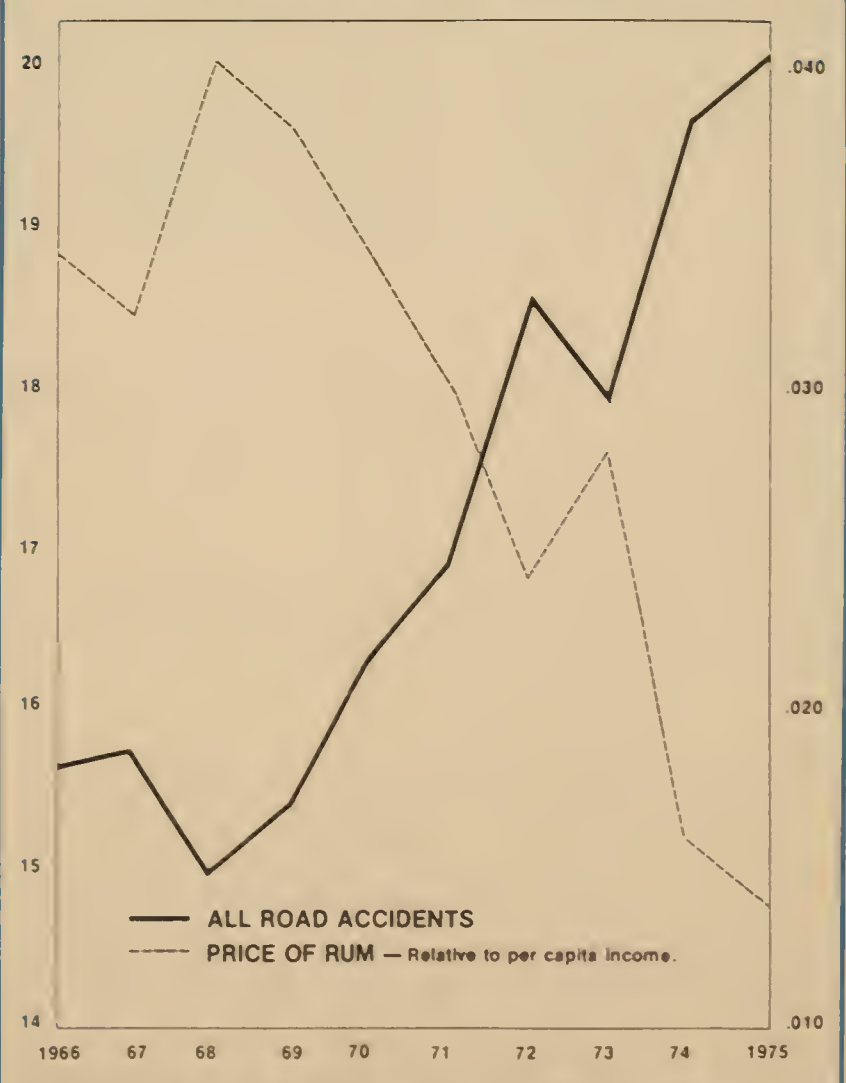
As well as assisting development of control mechanisms, such studies could be important in developing similar epidemiological principles for explaining alcohol and drug use; and in developing and testing similar measuring instruments.

However, "in general . . . there have not been many international studies concerned with alcohol and drug use. In fact, we're in the position of having to judge a beauty contest where there are not enough contestants," he said.



Reginald Smart

Price affects accidents



HIGH INCIDENCE of traffic accidents and fatalities is causing a great deal of public concern in Trinidad and Tobago. But, so far there has been a "reluctance to impute this to alcohol," according to Michael H Beaubrun. Dr Beaubrun is professor of psychiatry, University of the West Indies, Trinidad and Tobago, and director, Caribbean Institute on Alcoholism. Although he plans to carry out blood alcohol surveys of accident victims, Dr Beaubrun has meanwhile unearthed what he terms a "near-perfect inverse correlation between the figures for the relative price of rum and all road accidents" (there were 21,704 in 1976 in Trinidad and Tobago) and is "remarkable." "Clearly there is a need here for a breathalyzer even if only for the sake of accuracy in diagnosing the cause of accidents. More important still might be the need for adequate alcohol taxation to keep prices in line with the inflationary rise in the purchasing power of Trinidadians."

Researchers must be aware of local customs

KNOWLEDGE OF local traditions, attitudes, and beliefs is of "immense importance" for epidemiologists working in developing countries, says Rene Gonzalez.

For example, he said, when household interviews are conducted, especially in rural Latin America, respondents are often women.

'Women may fear reprisals from their husbands . . .'

"This may make it difficult to send out teams of male interviewers. Women may fear reprisals from their husbands for having agreed to the interview."

In most instances, he said, households are crowded and it is difficult to have privacy for the respondent to answer as sincerely as possible.

"In interviewing uneducated groups, one often finds respondents answering what they suppose is expected of them. Sophisticated concepts may seem totally irrelevant to the respondent, but he or she will answer anyway, hoping to 'please' the interviewer.

"These are problems found in all parts of the world but in our countries they need special attention."

Dr Gonzalez, regional advisor in mental health, Pan American Health Organization, regional office of World Health Organization, Washington, said researchers in Latin America "can and have benefited from experience and knowledge already accumulated in developed countries."

However, he added: "There is always the danger that research will be modelled after the American or Canadian experience without the proper adaptation to local conditions.

"Such adaptation refers not only to the correct translation of research instruments and utilizing local jargon, but also to cutting and adding appropriate items," said Dr Gonzalez

"Adaptation also involves an adequate study of the setting in which the research is to be conducted, an anticipation of the reactions and attitudes of the field staff and the respondents, and an evaluation of the material and human resources (available)."

Not only must a questioning attitude be adopted with respect to research designed in more developed nations, but also "we must develop in our scientists the capability and talent to identify the significant issues for study in Latin America and appropriate methods and technology for examining them.

"We cannot wait two years for the results of research in more developed countries to discover that one or another new drug of abuse is on the increase. These changes must be monitored at the local level by local investigators."

South America finds:

Program transplants fail

ALCOHOL AND drug-related problems take an especially high toll in developing countries where the measures, policies, and programs transplanted from more developed countries have failed to provide realistic solutions, according to Hector Acuna.

Dr Acuna is director of the Pan American Sanitary Bureau, regional office of the World Health Organization.

He said: "It is recognized these solutions can only be achieved through true technical cooperation among developing countries." Key elements in this, he said, are the establishment of networks of institutions in developing countries and provision of their professionals, in various disciplines, with tools and training relevant to solving their own problems.

"Insofar as the Region of the Americas is concerned, there is a great disparity in resources available for the field of drug dependence in the more developed countries, such as Canada and the United States of America, and the developing countries, which make up most of the population of the Region."

Yet, alcohol and drug abuse are "estimated to be at least as prevalent in the developing countries as they are in the more developed countries. In particular, alcoholism and related problems such as traffic accidents, loss of economic productivity, and social costs to communities, are increasing."

Dr Acuna explained that the concept of collaborating centres in drug dependence research and training was seen as a means by which WHO might foster the development of facilities and other resources for acquiring and disseminating new knowledge and for training personnel.

"Traditional technical assistance which implied a donor/recipient relationship and the dependency of the developing countries on the developed countries, has been found to delay rather than enhance the emergence of local capability. The fundamental impetus for this change of strategy is the need to generate new knowledge relevant to specific needs of the developing countries."



Hector Acuna

'There is a great disparity in resources available for the field of drug dependence . . .'

Judicial controls replacing family, religious controls

NON-MEDICAL USE of drugs is becoming one of the most serious public health problems in South America, Ayush Morad Amar told the seminar.

And while the problem differs in some respects from that in industrialized countries, for instance consumption of opium and its derivatives is not as widespread as in the United States, it is nevertheless as serious.

The phenomenon is partly due to incompatability between the functioning and efficiency of informal social controls and the structure of institutional controls, generally dominated by police and judicial institutions, said Dr Amar.

Under present development conditions in South American communities, the functioning of social controls over the community spheres of human behavior tends to broaden the sphere of the formal controls, diminishing the role of informal controls.

"The roles of the family, of the religious community, of the school and others, have been progressively replaced by controls stemming from judicial law and intentionally focused on the problem.

"However, only one phenomenon has been verified in South American countries as a whole: the increasing impersonality and complexity of living conditions in the urban environment, decisively affect the efficiency of existing social controls.



Ayush Morad Amar

"Concerning the consumption and abuse of drugs, it becomes difficult to maintain control if there is always a necessity to impose and adopt increasingly restrictive measures."

While the impact of drug use and alcoholism in South America depends as much on the way in which they were introduced and institutionally controlled, as on the individual, he said, there should be an equilibrium between pressures exercised by peers, family, cultural customs, and moral attitudes, and the legal norms and regulations.

'Roles have been progressively replaced . . .'

"Such an equilibrium should reduce the degree of risk of exposure to pharmacodependency. And formal societal response should be directed to the problems that affect this equilibrium, thus maintaining levels of use and abuse within socially tolerable limits, that is, within the limits that do not constitute public health problems.

"All formal social controls should . . . be directed to those behaviors that are not adequately controlled by the informal mechanisms of control. The formal mechanisms only aim at reinforcing the latter and should directly intervene only as a last resort.

"Drug policy, therefore, cannot form in an emptiness that separates traditional pharmacodependence from urban pharmacodependence. Any policy proposal for controlling drug abuse must consider its probable impact on user behavior, other social values, and the institutions themselves."

Severe alcoholism problem in Mexico

ALCOHOLISM IS "unmistakably a severe mental health problem in Mexico" although there is not enough research back-up to document the size of the problem.

"We cannot answer concretely what is the total number of alcoholics in the country," said Carlos Campillo-Serrano, coordinator of the area of social sciences research of the Centro Mexicano de Estudios en Farmacodependencia.

Despite lack of systematic epidemiological research, however, evidence of high alcohol consumption is emerging.

'A severe mental health problem . . .'

The death rate from hepatic cirrhosis, constant for the last 10 years, is an average of 20 per 100,000 people. This is higher than the same rate in Canada, the United States, and Italy, and, in South America, is second only to Chile's.

Death rates from alcoholism and alcoholic psychoses have been estimated at 4.5% per 100,000 population between 1963 and 1969.

Although suicide rates in Mexico are relatively low, an estimated 4% in 1967 were related to alcohol consumption, said Dr Campillo-Serrano.

And of 12,329 traffic accidents in Mexico City in 1973, 18% occurred while drivers were under the effects of alcohol.

'A remarkable increase in use of drugs . . .'

Dr Campillo-Serrano said concern about drug use in Mexico began toward the end of the 1960s. Before then, it was restricted to small groups.

Then the situation suddenly changed, and Mexican youths began adopting behavioral patterns similar to those prevailing among youths in other countries, said Dr Campillo-Serrano.

"There was a remarkable increase in the use of drugs such as marijuana, hallucinogens, and amphetamines.

"As a whole, the drugs most used (now) are marijuana, amphetamines, and stimulants. Heroin is seldom used. It also seems drugs are more widely used among people between the ages of 18 and 23 years."

In Mexico City, Acapulco, and Monterrey, inhalation of industrial solvents is also being noted, he said, particularly among children from 11 to 15 years and who belong to the lowest social classes and are without stable homes.

Addiction Research Foundation of Ontario
World Health Organization
Collaborating Centre
For Research
And Training
On Drug Dependence

Backgrounder

How WHO connection works: Archibald

In November, 1977, 28 years after he began the one-man operation that would become the now world-renowned Addiction Research Foundation of Ontario, H. David Archibald presided at ceremonies designating the ARF an international "centre of excellence".

Mr Archibald, who led the ARF for its first 27 years, and who for many years has acted as a consultant to the World Health Organization, is now executive vice-chairman of ARF.

In this interview with Anne MacLennan, editor of The Journal, **he discusses the meaning and significance of the ARF's designation by the World Health Organization as a collaborating centre for research and training on drug dependence.**

Q: What does the designation mean of the Addiction Research Foundation as a World Health Organization collaborating centre?
A: The WHO designation means, in essence, a partnership between ourselves and WHO, and a mutual commitment to work together to help people who suffer health and social damage as a consequence of the abuse of alcohol and other drugs. Certainly, it is a tribute to the foundation and its staff: the highest international body in the field of health, the World Health Organization, does not enter lightly into formal collaboration with organizations external to the United Nations system. This is a distinct recognition of the foundation as a major centre of excellence in this field.

Q: What, briefly, is the history of the concept of collaborating centres? Are there collaborating centres in other specialized areas?
A: The constitution of WHO specifies that the organization's objective shall be "the attainment by all peoples of the highest possible level of health." In attempting to achieve this objective, the WHO is committed to a policy of maintaining effective collaboration with the United Nations and specialized agencies of the UN, governmental health administrations, and other professional groups. One application of this policy has been the selection of centres of excellence in various fields and their designation as collaborating centres. This policy has been applied for a number of years in fields such as the neurosciences, mental health, and epidemic diseases, such as malaria.

Q: And in the alcohol and drug dependence field?
A: The Addiction Research Foundation in Canada and the Mexican Centre for Studies in Drug Dependence (CEMEF) are the first to be designated in this field.

Q: How did this appointment of centres in the alcohol and drug field come about?
A: In part, it's a response to expressions of concern by a number of governments not only in developed nations but in developing nations as well. This concern reflects the clear recognition that alcohol and drug-related health and social damage is now very widespread, and underlines the great need for strong international leadership.

It is clear that WHO or other United Nations organizations, by themselves, do not have sufficient resources to meet the needs in developing countries for technical knowledge and experience; for training professional and non-professional personnel; and for the examination and evaluation of programs, policies, and priorities, that may be relevant.

On the other hand, it is clear organizations such as the Addiction Research Foundation do contain a considerable body of knowledge and experience which, adapted appropriately, would be helpful to WHO and, through WHO, to the developing countries. It was decided to develop a broad international strategy, led by the WHO, involving designation of selected centres of excellence in various countries to work closely to exchange information and experience in this field. I should emphasize the word *exchange*. The process is, in fact, a 'two-way street'. Anyone who has worked in the international sphere always learns as much as is given.

Over the years, we've had many people from different countries coming to the foundation on exchange programs — sometimes for a relatively short period of time and a general orientation, sometimes for up to a year or more and a formal training program. In every instance, we have learned a great deal from our visitors, broadening our perspective, deepening our insights, and developing a much better understanding of the range of alcohol and drug problems and the similarities and differences that occur in different nations and different cultures. The fact the population of Canada and Ontario is comprised of people from a very wide range of nations and cultures adds to the importance of the foundation's having a broad understanding of the impact of alcohol and drugs on people.

Q: Isn't it rather idealistic to believe that experience in Canada, a developed country of 20-odd million people, can really do anything much to help, say India, a "developing" country of some 600 million? Or, that they can do much for us?
A: It is entirely possible that we can learn more from countries such as India or those in Africa, for example, than they can learn from us. Certainly, from us they can learn something about our experiences and, very importantly, perhaps learn some of the things they should *not* do.

But, there is much we can learn, particularly how they have developed with very limited human and financial resources, various kinds of services. They have had to face the very harsh reality of very small numbers of professional personnel in relation to need. Therefore, they've developed considerable experience in the use of 'paraprofessionals' in an area that is just beginning to emerge in Canada and the United States, an emergence which, incidentally, is brought about by the diminishing financial resources available for health care in these countries. We can certainly learn a great deal about how to develop low cost approaches.

I daresay our original health planners proceeded as if the human and financial resources were unlimited. As a consequence, our services are very costly and not always as efficient, on a broad scale, as the systems that have been developed in less affluent countries. On the other hand, we have been fortunate being able to afford the cost of acquiring technology and highly skilled professionals needed to conduct research — research that lies beyond the economic reach of many nations.

The major objective and challenge for both the developed countries and the developing countries is the application and adaptation of what is already known in our field, to the particular needs, and circumstances, of the community or nation.

Q: Given that ultimately it's the developed countries which have to pay for these kinds of programs, how would you reply to people who would question Canada's spending money and time and resources beyond its borders when there are so many unsolved problems at home?
A: With reference to cost, exchange of information and experiences is not a high cost item, and a fundamental question is the degree of commitment that is made.

Personally, I would hope very much that Canadians in general would be basically concerned about people throughout the world who do not have the tremendous advantages that we have had, who do not share our opulence and affluence, who can't even afford the food we waste.

However, there are some very practical matters to consider: it is in our direct interest to be concerned with the kind of program that may be developed in, for example, an opium and heroin producing area of the Third World like the Golden Triangle. About 85% of the heroin consumed by addicts in Canada originates there. If we are successful in the development of programs there, we'll depress the availability of heroin here and this is of direct relevance and importance to the health of our own people. I would submit we can't afford not to be involved.

In general, the people of the developing world aren't going to stand idly by, watching their children die from disease or hunger while we continue to clammer for an ever-increasing proportion of the world's luxuries. Instant global communication is bringing the message clearly to people throughout the world that there is no need, in this present day, for their children and their children's children to continue to suffer.

Inside Science

Intervention success

By Joseph Dietrich

THE RIDEAUWOOD program in Ottawa is a treatment centre for people with alcohol-related problems. The program begins with a one-week intensive health course at Algonquin Community College, with a two year follow-up. In the past year, more than 100 clients have been seen, and although definitive research data aren't available yet, professional and community staff are satisfied a majority of clients are regaining health.

The program is directed at early intervention; at the point when people begin to worry about their drinking, and are having difficulty controlling it.

Most of these people are still working; so Rideauwood has a two-day course for supervisors, managers, and union personnel; and a two-day course for health professionals.

The course for supervisors is an introduction to employee assistance programs and includes material on a wide range of social-health problems, discussion about company policy and procedures, the history and nature of EAP, skill training in interviewing problem employees, an examination of attitudes to social health problems and EAP, and an introduction to local and regional community resources.

The course for health professionals is a clinical orientation to alcohol problems. It contains discussion of all of the above as well as skill training in diagnosing and counselling people who may have alcohol-related problems. In the past year, more than 250 supervisors, union personnel, and health professionals, have attended the two-day courses.

The client course works like this: a person (including family members) calls for help. Within two days, they are given a clinical assessment interview by one of the staff (e.g. nurse, family counsellor, health educator, psychologist, recovered alcoholic etc,) to assess motivation and suitability for the course. If clients are serious about recovery, they are sent to their personal physician with a letter for permission to attend the course. The physician decides if the person needs a hospital bed, if the person can be dry from alcohol and drugs for the course, and whether there are any contra-indications re physical exercise, or any outstanding problems. After this letter is returned to Rideauwood, an admission decision is made. If doubt remains, the person may be admitted for assessment and possible referral to a lengthier program.

The client course has three main objectives:
(1) New knowledge about the cycle of stress and dependency so that change is possible.
(2) Examining interpersonal relationships.
(3) Learning new techniques of relaxation, nutrition, and physical exercise to replace sedatives.

The first part of the course beginning Wednesday, is an assessment of the client's cycle of dependency using the nine-part chart developed by Dr Gordon Bell of the Donwood Institute, Toronto. As the course progresses, the client is instructed in an individualized relaxation-fitness-nutrition plan and a recovery plan for the two-year follow-up program. The recovery plan is started on Friday, and developed over the weekend along with the fitness program. All clients are encouraged to attend an Alcoholics Anonymous or Alanon meeting. The recovery plan is completed on Monday and Tuesday, and includes the following priorities:
(1) Ways of staying dry (including a discussion of the possible use of Antabuse or Temposil).
(2) One recovery-oriented person to be honest with.
(3) One group as back-up. (The Rideauwood weekly group is available but a home AA group or therapy group is suitable).
(4) One change which is possible and effective.
(5) An individualized fitness program.

Each afternoon of the course, there is a session helping clients look at their interpersonal relationships and how they communicate through them. The primary therapist and his/her helper simply feedback the emotional reaction of the other members of the group to one another. No advice is given; rather, the person experiences the honest emotional feedback of the other group members.

On the final day, the half-hour morning assessment is extended to a 2½ hour exit session with staff and clients participating. As usual in every session, one staff member is designated to note pertinent happenings on the clients' charts. The exit group hears the opinion of each client on his/her progress and recovery plan. All clients and staff are allowed to comment and give advice at this time. This session is followed by a short half-hour staff meeting where any additional staff comments are finalized.

The health counsellor writes the exit letter which is sent to any contacts who have confidential files. The exit letter contains a complete assessment of the person's dependency including physical, psychological, and social aspects. The client's recovery plan, prognosis, and staff suggestions for individualized help, are also included.

The continuing therapy program is coordinated by the director, the health counsellor, the clinical secretary, and the alumni representative. The clinical secretary is a semi-paid volunteer who befriends the client, telephones each week, and sends a weekly staff letter with, perhaps, a personal word of encouragement. The alumni representative is a graduate of the program who wishes to assist new clients.

Evaluation studies are progressing, replicating the Day Clinic study done at Donwood. That study, completed in 1976, showed no significant difference in success rates between selected inpatients and day clinic patients one year after the four-week intensive treatment program. The Rideauwood evaluation studies are attempting to assess our success rate, one year after the intensive one week course, of a group of clients matched with the Donwood groups.

At Rideauwood, we are finding a one-week intensive course in a community college setting, followed by a two-year continuing therapy program, sufficient to help many people become healthier. This adaptation of the highly successful Donwood program has promise of being a simple, effective, inexpensive community application of a time-honored program.

* * *

(Dr Dietrich is director of the Rideauwood Institute)

UK report: five-point plan to combat alcoholism

By Thomas Land

LONDON — There is mounting evidence that a significant minority — perhaps half a million people in England and Wales and many more in Scotland — have a serious drinking problem.

The government's Advisory Committee on Alcoholism has just published a special report calling for public discussion on the growing problem of alcoholism and the misuse of alcohol.

The report sets out the following five-point plan to combat the problem:

- More health education to alert people to the dangers;
- A more balanced picture in advertisements and the mass information media of the effects of alcohol;
- The use of taxation to ensure that alcohol does not become cheaper in real terms;
- No relaxation of the licensing laws; and
- More encouragement to people with a drinking problem to recognize it and to seek help.

The report, which considers alcoholism in terms of the damage done to the lives of alcoholics as well as to those of people involved with them, has been welcomed by David Ennals, the secretary of state for social services.

Both Mr Ennals and John Morris, the secretary of state for Wales (and the minister to whom the Advisory Council reports) said the document is likely to make an important contribution to public discussion.

The strategy for prevention is really "everybody's business", the ministers say, for the harm from excessive drink is no longer limited to the caricature "drunk" or to a few homeless alcoholics.

The study, *Report on Prevention*, says a person's "reasonable claim to be free of drink" needs to be balanced with "the equally reasonable claim to be protected from the consequence of the misuse of drink". It says that it would be disastrous if its strategy were seen as interfering with the right of people to enjoy themselves, and that the primary responsibility for each individual's health and well-being lies with himself.

But he has a claim to be informed of, and protected from, the consequences of the misuse of drink. To be successful, preventive measures need "to command broad approval from society at large". The report therefore calls for stronger social controls, moderation in drinking, social acceptance of abstinence, and strong disapproval of inebriety. This, the committee advises, should be the message taught to both adolescents and adults. Health education should be encouraged and expanded.

Thus the committee called for a more balanced picture of alcohol in the media, including advertisements, television and radio, and for advertisements to take a "more positive role" in discouraging alcohol misuse.

It accepts evidence that the more alcohol is consumed in a society, the more alcohol-related harm there is likely to be, and that the price of drink has a significant effect on the amount consumed.

The report therefore calls for tax to be adjusted to ensure that alcohol does not become cheaper in real terms. It also calls for the maintenance of existing pub licensing hours and age limits.

The authors of the report say sales promotion should not encourage impulse buying, and they express concern about supermarket off-licences. Finally, the committee stresses the importance of identifying people who are developing a drink problem at an early stage.

The advisory committee's recommendations have some points in common with those of the House of Commons' Select Committee on Expenditure whose *First Report on Preventive Medicine*, was published in February. Both committees see a need for a range of preventive measures. Their recommendations concern many government departments which are currently being consulted.

As a result of the current discussions, the ministry of health is to publish a consultative document on alcohol next year. That document is expected to contain a detailed discussion of the recommendations of both committees, including arguments both in favor and against. The views of health and social service authorities, professional, voluntary, and trade organizations will be invited at that stage.

The Advisory Committee on Alcoholism was established in 1975. It is chaired by Neil Kessel, professor of psychiatry, Manchester University. A recent study in the government's *Population Trends* considered a range of evidence and concluded: "Our calculations suggest it is reasonable to accept as a minimum the estimate of the department of health that there may be 500,000 people in England and Wales with a serious drinking problem".

These were the major recommendations of the parliamentary select committee:

- A larger proportion of the £2,000 million raised in duty and taxation on alcohol should be devoted to educating children and young adults about the dangers of alcohol dependence;
- The money remaining in the Licensing Compensation Fund should be released for health education purposes;
- Television should be more extensively used to put across the dangers of alcohol abuse to particular identifiable groups;
- The price of alcoholic drinks should remain at the same level relative to average incomes as now, and should not be allowed to become a relatively cheap item in the shopping basket;
- The age at which alcohol is made legally available should in no circumstances be lowered;
- The government should instigate, and support, research into the identification of those groups of drinkers most at risk; and
- The inevitable overlap of preventive work being done by various bodies to counter alcoholism should be reduced by coordinating those bodies under a single umbrella organization.

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Around the World

Heavy traffic

People living near freeways may take far more tranquillizers, anti-depressants, and sleeping pills than those who live in quiet country areas, according to a five-year study of an English village. The study showed that the 1,500 villagers living by a main road were prescribed more drugs than people living in a similar village away from the main road. The residents who lived by the busy road took three times as many tranquillizers and anti-depressants, and about four times as many sleeping pills as their more isolated neighbors. After a by-pass was constructed, diverting trucks away from the busy village, the consumption of drugs was more than halved. Men and women had taken roughly the same number of sleeping pills, but women had taken more tranquillizers and anti-depressants — probably because they spent more time in the home, the study stated.

Stronger brew

Sweden's drinkers have started consuming stronger beer since the government banned the sale of medium strength beer in supermarkets in July, 1977. The beer with a 2.6% alcohol content was prohibited in a move to cut down heavy drinking by young people, but supermarkets were allowed to carry beer with a 1.8% alcohol content. A leading Swedish brewery, however, claims the medium strength ban has given sales of its strong beer (4.5% alcohol content), an unexpected boost. Sales are up 60% over 1976 statistics, although strong beer can only be purchased through the state liquor monopoly.

Cut-price beer

Australia's state of Victoria has introduced resale price maintenance to stop cut-price sales of beer. Victoria's liquor control commission has set the minimum price of beer at 68 cents for a 740 ml bottle. No discounts are to be allowed for purchases of a dozen or more bottles as in the past. Some Victoria supermarkets that were operating cut-price sales have had to raise the price of beer by about $1.20 (Australian) per dozen bottles.

Pregnancy

The Queensland Health department in Australia has released a brochure highlighting the risk of damage to an unborn baby when the mother smokes. Smokers' babies are likely to be smaller and stay smaller — if they do not become part of the higher stillbirth rate, the brochure states. In launching the brochure, Health Minister Dr Llew Edwards said doctors' questions to an expectant mother about smoking should be as routine as those about German Measles.

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cannabis cannabis canna

factsheet

Marijuana and hashish are obtained from the hemp plant *(Cannabis sativa)*. The ingredient in cannabis that produces the typical effects on mood and perception is called THC (tetrahydrocannabinol).

APPEARANCE

Marijuana is composed of the flowering tops and leaves of the hemp plant, and frequently contains seeds, stems, and other materials Marijuana ranges in color from greyish green to greenish brown, and in texture from a fine substance that looks like oregano to a coarse substance that looks like tea.

Hashish is the dried caked resin produced from the tops and leaves of the female plant. Hashish usually contains a higher concentration of THC than marijuana, and is therefore the more potent preparation. (Potency refers to the amount required to produce a given effect). Hashish is sold in solid pieces; its color ranges from light or medium brown to nearly black. The texture varies from soft to hard. A reddish brown oily extract of cannabis is occasionally sold by street dealers under the name of 'liquid hash', 'hash oil', or 'honey oil'; this is the most potent preparation other than pure THC.

Marijuana is usually smoked in hand-rolled cigarettes or special pipes. Hash smoke is inhaled in a variety of ways. Cannabis preparations may also be swallowed, usually mixed with food. The effects appear more rapidly with smoking and are more under the control of the experienced user. It is not possible to inject cannabis preparations.

EFFECTS

The effects of any drug depend on the amount and the way it is taken, previous drug experience and the feelings of the user, whether alcohol and other drugs are taken at the same time, and the circumstances surrounding its use, including the presence of other people.

Short term effects are those which appear rapidly after a single dose is taken and disappear within a few hours or days.

The most common short term effects of a small dose of marijuana are:

a) The 'high' — a feeling of euphoria, and a tendency to talk and laugh more than usual. This is similar in many ways to mild alcohol intoxication;
b) An increase in the pulse rate;
c) Reddening of the eyes;
d) A later stage in which the user becomes quiet, reflective, and sleepy.

The whole experience is usually over in a few hours. At larger doses, these effects are increased, and the user may misjudge the passage of time, so that a few minutes may seem like an hour. Perception of sound, color, and other sensations may be sharpened or distorted.

Cannabis impairs short term memory, logical thinking, and the ability to drive a car or perform other complex tasks. When cannabis is combined with alcohol, barbiturates, or certain other drugs, it increases their effects on thinking and behavior. At very large doses, the effects of cannabis are similar to those of LSD and other hallucinogenic drugs. The user may experience confusion, restlessness, excitement, and hallucinations. These may cause anxiety or panic, and even precipitate a true psychotic episode.

Long term effects are those provoked by repeated use over a long period of time. Cannabis has not been as extensively used in North America as some other drugs, particularly alcohol, and until a drug has been used on a large scale for a significant period of time it is difficult to attribute the increase of specific diseases to its use. The following effects of cannabis have been observed in some users:

a) Moderate tolerance develops — more of the drug is needed to produce the same effect.
b) THC is soluble in fats and so will concentrate in fatty tissue in the body, including in the brain where there is a high percentage of fat. With continued use the level in the body builds up and is gradually released into the body system.
c) About one out of 20 regular users become psychologically dependent on cannabis; the drug becomes so central to the person's thoughts, emotions, and activities that it is extremely hard to stop using it. The possibility of physical dependence (a state where withdrawal symptoms are noticeable if drug use is stopped abruptly) cannot be ruled out.
d) Heavy users of cannabis also tend to be heavy tobacco smokers. The tar content of cannabis smoke is at least 50% higher than that of tobacco. Heavy cannabis users therefore run an added risk of lung cancer, chronic bronchitis, and other lung disease.
e) Regular heavy use, especially by teenagers and young adults, may lead to loss of energy and drive, slow confused thinking, impaired memory, and lack of interest in any planned activity. This is called the 'amotivational syndrome'. It is difficult to create an accurate measure of subtle changes in mental state that might cause this syndrome, and insufficient comparison has been made of marijuana users' motivation before and after regular use of the drug.
f) Physical discomforts such as diarrhea, cramps, weight loss or gain, blockage of blood vessels, and loss of sex drive have been attributed to marijuana use in some cases.

Some physicians treating marijuana users associate the following symptoms with chronic heavy use; chromosome damage, reduced levels of male sex hormone in the body, reduced body defenses against infections, brain and liver damage. These have not yet been demonstrated to be directly linked with marijuana use.

WHO USES CANNABIS?

Recent Canadian research shows that about one out of five students report having used cannabis in the preceding six months. About one out of 12 adults report having tried cannabis. Cannabis users are more likely to live in large cities than in small towns or rural areas.

It is estimated that there are about one and a half million continuing users of cannabis in Canada, the great majority of whom are infrequent users.

People report a wide variety of reasons for using cannabis. They may begin out of curiosity or because of social pressure, and many stop using it once their curiosity is satisfied. Those who continue to use cannabis moderately report that they like the feeling of well-being and relief from tension. Some people take it as a relief from boredom, frustration, or depression.

Regular heavy users also tend to be users of other drugs such as alcohol, LSD, or amphetamines.

CANNABIS AND THE LAW

Cannabis sativa, its preparations, derivatives, and similar synthetic preparations, are covered by the Narcotic Control Act, and it is therefore illegal to be in possession of these substances unless authorized by the Act or the regulations.

A summary conviction for possession (first offence) carries a penalty of up to $1,000 and/or six months imprisonment. First offenders may receive absolute or conditional discharge, and may request that their criminal record be erased after one year or more of good conduct. For subsequent offences there is a fine of $2,000 and/or imprisonment for one year. An indictable conviction for possession carries a maximum penalty of up to seven years. An indictable conviction is more severe than a summary conviction.

Trafficking, importing, exporting, and cultivation are all indictable offences. The penalty for trafficking is life imprisonment, for importing or exporting, it is imprisonment for between seven years and life, and for cultivation the penalty is imprisonment for up to seven years.

Bill S-19, transferring cannabis to the Food and Drug Act, has been passed by the Senate and has had two readings in the House of Commons. If it is passed, penalties for cannabis offenses will be less severe and more flexible, with provision for summary offences for trafficking, importing, exporting, and cultivation. Simple possession would no longer be an indictable offence.

1976 Addiction Research Foundation of Ontario.

The Journal

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Clip this page

New Books

by RON HALL

America's No 1 Drug Problem

. . . by James E. McReynolds

This book is intended as a guide to enable increased awareness of the role of adults, youth, parents, neighbors, and friends in the prevention or minimization of alcohol problems within the family. Alcoholism is discussed within the context of coping with life, and as an emotional, physical and spiritual problem. Although the focus of the book is prevention, resources for referral, counselling, and treatment are offered.

(Broadman Press, 127 9th Avenue North, Nashville, Tennessee, 37203. 1977 154p).

Marihuana Research Findings: 1976

. . . edited by Robert C. Petersen

This volume is the more detailed reference report which provided the basis for the shorter sixth edition of the Marihuana and Health Report. Epidemiology, chemistry and metabolism, toxicological and pharmacological effects, preclinical effects, human effects, and therapeutic aspects are presented in this report which is likely of interest to the technically trained reader.

(National Institute on Drug Abuse, 11400 Rockville Pike, Rockville, Maryland, 20852. 1977 259p.).

Other Books

Hallucinogens And Culture — Furst, Peter T. Chandler and Sharp Publishers, Inc., San Francisco, 1976. Tobacco, cannabis, LSD, mushroom, peyote, hallucinogenic snuffs. 194p. $5.

Youth Alcohol Safety Education Curriculum For The Secondary School — McPherson, Kenard, Ashburn, Sarah, and Knipper, Anne. National Public Research Institute, Alexandria, 1976. Alcohol education, youth drinking and driving, characteristics of drinking drivers. 121p. $6.

The Epidemiology Of Drug Abuse: Current Issues — Richards, Louise, G., and Blevens, Louise B. (eds). US Government Printing Office, Washington, 1977. NIDA Research Monograph 10: transcripts from the Conference on the Current Issues in Epidemiology of Drug Abuse held in Miami Beach Nov 18-19, 1974. Incidence and prevalence, data acquisition, applying and extrapolating data. 259p.

Alcoholism And the Elderly: A Study Of Problems And Prospects — Gordon, Judith J., and Kirchoff, Karen L. Elderly Program Development Center Inc, Iowa City, 1976. Agencies involved in alcoholism and the aged, consumption of alcohol in the US, surveys, bibliography, tables. 128p. $5.50.

Drinking Behavior, Attitudes, And Problems In Marin County, California — Cahalan, Don, and Treman, Beatrice. Social Research Group, School of Public Health, University of California, Berkely, 1976. "Report of a sampling survey of Marin residents aged 18 and older." Tables, appendexes. 127p. $6.

The Therapeutic Community — De Leon, George, and Beschner, George M. (eds). National Institute on Drug Abuse, Rockville, 1977. "Proceedings of Therapeutic Communities of America Planning Conference" Jan 29-30, 1976. 115p.

A Study Of Ex-Heroin Addicts In A Methadone Treatment Program And Their Employability — Pugliese, Anthony Charles. Rutgers University, New Brunswick. Tables, figures, appendexes, references. 155p. $23.50.

Social And Economic Aspects Of Drug Utilization Research — Conley, Bernard E. Drug Intelligence Publications, Inc, Hamilton, 1976. "An overview of the state of knowledge, an analysis of outcome of federally supported research, and a digest of relevant literature for a period from 1960 to 1975." 276p. $47.50.

Primary Prevention In Drug Abuse: An Annotated Guide To The Literature — Messolonghites, Louisa. US Government Printing Office, Washington, 1977. Appendexes, indexes. 205p.

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six point scale. For further information, contact Linda Chung, coordinator of the group at (416) 595-6150.

Cross Country High

Subject Heading: Alcohol and alcoholism — Overview, sports, attitudes, and values.
Details: 16 minutes, 16 mm.
Synopsis: Ten-year-old Eddie has entered a cross country race. Unfortunately, Eddie lacks confidence in his ability to compete successfully with his friends. While the friends are practising, Eddie meets some boys who persuade him to try drinking wine. Eddie has a few drinks and feels that he can now beat anyone in the race. On the day of the race, Eddie drinks some of his father's wine to help him win the race. However, he experiences a stomach ache and is forced to drop out. He realizes that alcohol does not help, and vows never to drink in that way again.
General Evaluation: Fair (3.1)
Recommended Use: Audiences of 14 years of age and under.

Why Be Down When You Can Be Up

Subject Heading: Attitudes and values, drug use. Etiology and Epidemiology.
Details: 16 minutes, 16 mm.
Synopsis: Two young men are smoking marijuana when one of them is caught by police. Norman escapes, and the next time we see him, he is smoking marijuana in a tree. He is startled by a "voice" asking him to explain his use of marijuana. The voice illustrates to Norman what being high all the time can do to a person, and how good feelings must be balanced with unpleasant feelings as part of one's normal life.
General Evaluation: Poor (2.2)
Recommended Use: Should not be shown.

The New Life of Sandra Blain

Subject Heading: Women and alcohol/employee assistance program.
Details: 27 minutes, 16 mm.
Synopsis: Sandra answers a call for help from a woman who has difficulties in quitting drinking. Sandra tells the woman she understands, and recalls her own drinking days when she lost her husband, children, and ended up in a rehabilitation home. Sandra learns to type and finds a good job where she works hard. When the court denies her suit to regain her children she feels defeated. A neighbor offers her a drink, and Sandra takes it. In a short while, Sandra's work suffers, and her drinking becomes heavier. Finally her employer forces her to get help, and Sandra rejoins her therapy group.
General Evaluation: Very good (5.0). A contemporary, informative, interesting, and realistic filling with a clear message, and a powerful emotional impact. This film was rated as an excellent teaching aid.
Recommend Use: Likely to benefit audiences of 15 years of age and older.

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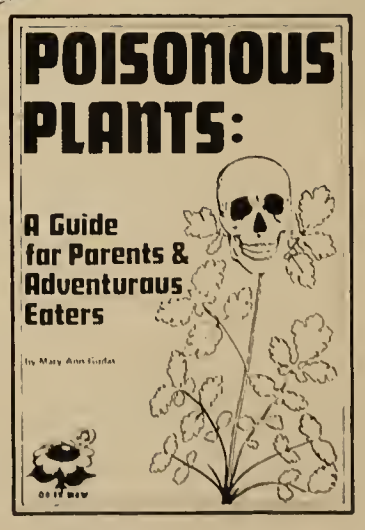
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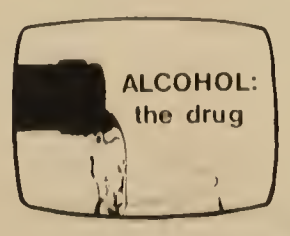
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Canada

Detox Workers Training Program — Jan 23-27, Feb 20-24, April 24-28, 1978, Toronto, Ontario. Information: Diane Hobbs, coordinator, Detox and Rehabilitation Programs, Addiction Research Foundation of Ontario, 33 Russell St. Toronto, Ont, M5S 2S1.

10th Banff International Conference on Behavior Modification — March 19-23, 1978, Banff, Alberta. Information: Donna Fraser, coordinator, Banff International Conference on Behavior Modification, 603, 733-14th Avenue SW, Calgary, Alta.

AADAC Summer School on Alcohol and Drugs — Sept 22-23, 1978, Kananaskis, Alberta. Information: Marg Bailey, Alberta Alcoholism and Drug Commission Community Extension Services, 2nd floor, 812-16th Avenue SW, Calgary, Alta, T2R 0T2.

13th annual Conference of the Canadian Addictions Foundation — Sept 24-29, 1978, Calgary, Alberta. Information: Mr Stuart Hutton, conference manager, Action Plan '78, 812-16th Avenue SW, Calgary, Alta, T2R 0T2.

United States

Alcoholism — The Search for the Sources — Jan 15-21, 1978, Greensboro, North Carolina. Information: John Ewing, director, Center for Alcohol Studies, The University of North Carolina at Chapel Hill, Medical School Building, Wing B 207 H, Chapel Hill, NC, 27514.

5th National Drug Abuse Conference — April 3-8, 1978, Seattle, Washington. Information: NDAC-78, 200 Broadway, Seattle, Wash, 98122.

International Arctic Rim Conference on Alcohol Problems — April 16-20, 1978, Fairbanks, Alaska. Information: International Council on Alcohol and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

Abroad

4th International Conference on Alcoholism and Drug Dependence — April 9-14, 1978, Liverpool, England. Information: Merseyside, Lancashire and Cheshire Council on Alcoholism, B 15, The Temple, Dole Street, Liverpool, L2 5RU, England.

International Conference on Alcoholism and Drug Dependence — May 22-26, 1978, Caracas, Venezuela, Information: ICAA.

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AT-013 CHANGING THE DRUG DEPENDENT LIFESTYLE

21 minutes *by Anne McKay*

Lifestyle change is a difficult challenge facing alcohol and drug abusers. Anne McKay, formerly an occupational therapist with the Addiction Research Foundation of Ontario, discusses leisure related problems, leisure counseling, and the basics of a leisure service. Program planners, counselors, occupational therapists, and recreationists should find this information useful, not only in assisting alcohol and drug abusers but also in developing preventative mental health, pre-retirement, community re-entry, and other lifestyle change programs.

AT-014 SOLVENT AND AEROSOL ABUSE

25 minutes *by Alec Gabe, Frederick Glaser, and Adrian Wilkinson*

What are solvents and aerosols? Who abuses them and why? What can the community do about it? These questions and others are explored in a wide-ranging discussion including Mr. Alec Gabe, information counselor; Dr. Frederick Glaser, head of psychiatry; and Dr. Adrian Wilkinson, clinical psychologist; all with the Addiction Research Foundation of Ontario. Approaches to the management and control are presented along with a discussion of the evaluative process.

AT-015 DRINKING-DRIVING COUNTERMEASURE PROGRAMS

24 minutes *by Pamela Ennis*

The focus in this presentation by Dr. Pamela Ennis, a scientist with the Addiction Research Foundation of Ontario, is on drinking-driving countermeasure programs. Strategies of primary, secondary, and tertiary intervention are considered and their effectiveness is discussed in the context of general and specific deterrence.

OTHER CURRENT TITLES

AT-001 **PREGNANCY AND DRUGS** *by Barbara Tucker*

AT-002 **FAMILY THERAPY** *by Reesa Kassirer*

AT-003 **WOMEN AND PSYCHOTROPIC DRUGS** *by Ruth Cooperstock*

AT-004 **COUNSELLING THE CHILDREN OF ALCOHOLICS** *by Kathleen Michael*

AT-005 **DETOX CENTRES — THE ALTERNATIVE** *by Dianne Hobbs*

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AT-007 **CONTROLLED DRINKING CONTROVERSY** *by Norman Giesbrecht*

AT-008 **THE WOMAN AND HAZARDOUS DRINKING** *edited by Deborah Levine*

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AT-010 **EMPLOYEE ASSISTANCE PROGRAMS: An Overview for Employers** *by Bryan White*

AT-011 **OUTPATIENT TREATMENT OF THE ADULT ALCOHOLIC** *by Michael Jacobs*

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TRUST CONTROL

. . . New Zealand's prohibitionist legacy

By Pat McCarthy

AUCKLAND, NZ — The temperance wave that swept down from North America last century, left New Zealand a lasting hangover of ambivalent attitudes to alcohol.

Of more interest to the student of alcohol control, is a side-effect of that temperance movement — a licensing trust system which operates in more than 30 communities, in uneasy coexistence with the private enterprise that controls most of the country's liquor trade.

Trust control — based on the idea that a community, through a group of locally elected citizens, should control its own liquor supply — was born nearly 34 years ago. Opinions are sharply divided on whether this social experiment has been a benefit or a failure.

Strong reaction to the abuse of strong drink in New Zealand dates back pretty well to whalers from the New England ports of Sag Harbor, Salem, and Nantucket who, along with their British and French competitors, introduced grog in earnest in the early 1800s.

A book on the formation of a temperance society came off a missionary press in 1836 — it was New Zealand's first book printed in English. Supporting a Methodist move to ban spirits completely, James R. Clendon, the first United States consul, punctured the casks in his personal cellar and drained them into a creek.

Virtually no consistent control of liquor licensing existed before 1881. During these years, and into the early part of this century, bitter controversy over alcohol came to dominate the political scene. Brewers and publicans fought tooth and nail against women's suffrage (enacted in 1893, second only to Wyoming) for fear of what an enfranchised temperance lobby might achieve.

Local option polls turned many communities dry. In 1919, buoyed by victory in the United States, national prohibition received 49.7% support — just 3,263 votes short of the required majority. Then the temperance wave receded. (A triennial referendum persists. In 1975, the prohibition vote was 15.8%.)

When, in 1943, the country's southernmost city of Invercargill voted itself wet after 37 dry years, memories of the sawdust and swill standards of pre-prohibition pubs were still alive in the minds of many townsfolk. Anxious to avoid a return to former abuses, they looked for a fundamental change in the system of control.

When they heard the town council in Renmark, South Australia, had for 40 years run the local hotel, a spirited campaign for community ownership began.

The Labour Government of the day was receptive. But Invercargill's city council refused to operate hotels. The scheme might have ended there if a government secretary, a Scotsman, had not provided information about Britain's Carlisle experiment.

In 1916, when drunkenness was interfering with the war effort, the British government had set up State management districts in four centres of munitions manufacture and naval bases. (In Carlisle, the "experiment" continued until 1973, when control returned to private enterprise.)

New Zealand Prime Minister, Peter Fraser, is said to have slept on the idea of writing a licensing trust provision into the law. Next morning he announced: "We'll put it in."

Invercargill's new trust soon earned a name for innovations — not all successful. Introducing liquor to an existing restaurant, where women and children took tea and cakes, proved to be 20 years ahead of its time. So did sit-down drinking in bars. Taverns and lock-up suburban bottle shops, both then new to the country, were more popular.

Now, the six elected trustees — who cater for New Zealand's keenest beer drinkers, 35 gallons a head in 1976 — run one of the city's biggest businesses, owning assets worth $20 million. It has five hotels, six taverns, four bottle shops, two wholesale liquor outlets, three wine shops, a catering establishment, a market garden, and a motel.

Of 33 other trusts which have followed Invercargill's example, two have gone broke, and others have struck severe liquidity problems entering a capital-intensive and price-controlled industry in competition with neighbouring brewery interests. In spite of vigorous anti-trust campaigns by the private liquor industry, a score of other former no-licence areas voted for trust control, but for financial and other reasons have failed to launch a trust.

For all that, little distinguishes trust operations from those of private interests. Trusts operate like private companies and pay company tax, although their annual reports are tabled in parliament.

The original legislation decreed trusts should establish "model hotels," conduct them "in the interests of the public wellbeing," and distribute profits "for public purposes." In practice, the community sees only about 5% of pre-tax profits in donations to cultural and recreational projects.

Like the public's attitude to alcohol, the private sector's stance toward trusts is ambivalent — seeing them both as socialistic competitors and as customers. Trusts buy their beer from breweries in the same way as other wholesalers. Trusts hold stock in breweries and in other liquor distributors. Several trusts are partners with private interests in brewing and beer-bottling ventures.

The trust movement, however, is a separate system of control. Largely for this reason, the National Society on Alcoholism and Drug Dependence holds strong reservations about the whole concept.

Its president, Roy H. Johnston, sees trusts as a substitute for residual pressures which arose out of the prohibition movement. Some former opponents of alcohol, apparently believing in "an alchemy which makes beer out of a trust pump unsinful, and incapable of producing problem drinking," sublimate their emotive attitudes in support of trust control, he says.

"When, eventually, the history of New Zealand's tortured journey to alcohol normality can be written," he adds bluntly, "the trust movement will be recorded as a tragic mistake, exactly as was the movement to prohibition."





Some local communities in New Zealand control their own liquor supply — opinions are sharply divided.



Roy Johnston

'When, eventually, the history of New Zealand's tortured journey to alcohol normality can be written, the trust movement will be recorded as a tragic mistake. . .'

THE BACK PAGE

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The Journal

Vol. 7 No. 2 2nd Class Mail Reg. No. 2776 **Published monthly by Addiction Research Foundation** TORONTO February 1, 1978

Humanities & Social Sciences

Director quits the troubled CAF

By Karin Pargas and Anne MacLennan

TORONTO— In a surprise move, Francoise Berthiaume has resigned as executive director of the Canadian Addictions Foundation, a non-governmental advocacy and clearinghouse agency.

She resigned in January following a telephone conference of board members called by Marvin Burke, CAF president since July, 1977. Ms Berthiaume participated in the meeting.

The meeting focused on the need for budgetary restrictions, long a critical concern of CAF which depends for financial assistance largely on government funding and membership fees.

Mr Burke disclosed Ms Berthiaume's resignation, effective Jan 31, in a telephone interview with **The Journal**.

He said from the beginning of this month, the CAF central office (secretariat) in Ottawa would operate permanently without an executive director. He said he had appointed two staff members to new positions to carry out administrative duties.

Glen Wilson, program director under Ms Berthiaume, would retain his duties and, in addition, act as executive secretary to the 15-member foundation's board of directors. Raun Kipp would act as office manager in charge of budgets, he said.

Ms Berthiaume joined the foundation in January, 1975, as information director, and was appointed acting executive director in September, 1975. This was after Dennis Taylor, the first executive director, appointed in early 1974 resigned suddenly. In January, 1976, Ms Berthiaume was named executive director.

Ms Berthiaume told **The Journal** she had been offered a reclassification of her position to executive secretary and program coordinator, which would have combined essential functions of two present staff members. The reclassification included a salary reduction.

"I have declined to accept the new position since it is not suited to my interests and career plans. However, I appreciate the necessity of retrenching at this time, and because I believe the foundation is a needed and worthwhile organization, I will continue to work for the foundation as a member on a voluntary basis to the best of my abilities."

Mr Burke, executive director of the Nova Scotia Commission on Drug Dependency, said the board had been "thinking about reorganization and personnel" for some time. (In January, 1977, the CAF central office consisted of four staff members, and two contract part-time positions).

"We have as a board looked at the organization and said . . . a secretariat doesn't have to be massive . . . We at no time should have more than four people. At this point, we are down to 2½. That's what I have cut it to — 2½ people — all very skilled."

Referring to the early days of the still-troubled foundation, then the Canadian Foundation on Alcohol and Drug Dependencies (CFADD), he said: "Someone got the idea that we ought to have a secretariat, and they got into this business of major organization, and budgets, and funds. Ottawa was approached, and they were nice enough to give us a hand. But I think the organization went all over the place — my personal opinion. It took a big leap without being able to crawl in the first place, and then walk slowly.

"Well, all of a sudden we had an executive director (Dennis Taylor), a big salary being paid, great expectations, tremendous paper being poured out in terms of the future of the foundation. But there were no monies, there were no plans as to how to go about this. And even the nature of the board wasn't investigated."

Whether its acronym be CFADD or CAF, the foundation is weathering continuing financial storms. (**The Journal**, October, 1975).

(See — CAF — page 4)



Francoise Berthiaume



Marvin Burke

Liberal marijuana bill is languishing

OTTAWA — The bill to liberalize Canada's marijuana laws has slipped into bureaucratic limbo once again.

Promised more than four years ago, the legislation has already passed through the Senate side of Parliament, but has yet to make it to even an advanced state of consideration in the House of Commons.

Having failed to be passed last year, the bill is now languishing before a special interdepartmental committee whose avowed purpose is to modify the legislation to take into consideration amendments proposed by a Senate committee and to adjust the bill to changing times.

Public cold — page 3.

Since the legislation must now be reviewed by the Cabinet and then redrafted before it can be resubmitted to Parliament, it is highly unlikely the cannabis bill could be passed into law before this summer at the earliest. Complicating the situation even further is the possibility of a spring or summer federal election.

As originally proposed, the legislation was to transfer marijuana and hashish crimes from the Narcotic Control Act to the less stringent Food and Drugs Act. Jail sentences for first offence cannabis possession were to be eliminated and penalties for most other cannabis crimes redueed substantially, to a level approaching the average already being imposed in most (but still not all) courts in Canada.

The office of new federal health minister, Monique Begin, has refused a request from The Journal for an interview with the Minister on the grounds that the government's drug policies are up in the air until the interdepartmental committee reports to the government on the cannabis legislation.

Meanwhile, cannabis crimes continue to be the number one feature of annual drug statistics, police drug enforcement efforts, and the government's drug user files.

***As a counter to wine sales*:**

Brewers hope to see the 'light'

By Bryne Carruthers

OTTAWA — Canada's major beer makers are taking a new tack in the continuing struggle to recapture the growing number of drinkers who have been switching from lagers and ales to imported, domestic, and home-made wines.

After observing a phenomenal turn-around in this trend south of the border, Canadian brewers are going to try marketing lower alcohol and lower calorie beers.

The hope is that weight-conscious Canadians, particularly women, will decide the beer doesn't necessarily mean "tire tummy," and that the lighter taste of the "light" beers will be more palatable to a greater segment of the drinking market.

On the one hand, government officials are excited (unofficially, of course) about the prospect of lower alcohol beers. The feeling or, more appropriately, the hope, is that the new beers will lead to a significant reduction in amount of alcohol consumed.

But the hope and excitement have been caught up in some interdepartmental wrangling and some legal squabbles.

Labatt's Breweries of Canada Ltd, the first on the Canadian market with a lower-alcohol beer (about 4% alcohol, down from the average in Canada of slightly in excess of 5%), ran afoul of lawyers from the department of consumer and corporate affairs who took the "Special Lite" beer to court only days after it was introduced in Ontario and British Columbia.

The court case, lost in the first round by the government, was based on a regulation under the Food and Drugs Act defining "light" beers as ones with no more than 2.5% alcohol content.

Labatt's argued that the "lite" in its new product's name referred to calories, not alcohol. The argument seemed to convince the BC court, despite the government's counter-argument that this approach was in fact the equivalent of misleading advertising. Consumer and corporate affairs, which is now considering whether to appeal, believes changing the word from "light" to "lite" shouldn't sweep aside government regulations.

Meanwhile, Carling O'Keefe Ltd of Toronto was reported to be preparing to jump into the

(See — Wine — page 4)

Many 'dramatic changes' after prison drug study

By John Shaughnessy

OTTAWA —A recently-released report which claims Canada's federal prisons promote excessive and inappropriate use of drugs, gives an inaccurate picture of the present situation, says the head of medical services for the Canadian Penitentiary Service.

"The picture now is not as black as that painted in the report," Daniel Craigen told **The Journal**. Dr Craigen is director general of medical and health care services for the penitentiary service.

The report, by the National Health Services Advisory Committee, to the Commissioner of Penitentiaries, deals with the provision of all medical and health care services in federal prisons. It was adopted in 1975 and not released to the public until December, 1977.

Dr Craigen refused to say why there was a two-year delay in the report's release to the public. However, he stressed that, in the interval, "dramatic changes" have been made and controls on drug use and distribution have improved substantially.

The committee, headed by Dr E. H. Botterell, found that in many, if not most institutions, there were no effective

(See — Prison — page 5).

A special report on South America, by Harvey McConnell, begins on page 7.

BLACK-JAC



The new drug fad — see Inside Science, page 6.

Regular features

- *Wayne Howell* 2
- *Letters to Editor* 11
- *Around the World* 12
- *New Books* 14
- *Projections* 14
- *Coming Events* 15

UK launches a blitz on drinking and driving

By Alan Massam

LONDON — The British government seems set to make 1978 the year for increasing effort against the problem of alcohol abuse.

William Rodgers, minister of transport, has announced substantial increases in state money to be spent on "stay off drink while driving" publicity, and health secretary David Ennals is known to be preparing for a major blitz on the alcohol problem.

The ministry of transport cash will be to the tune of £1,000,000 spent on television, radio, newspaper, and street advertising as part of a £4 million road safety budget.

Mr Rodgers has been moved to act against drinking and driving by the latest road accident statistics which show that during 1976, nearly 12,000 drivers involved in accidents on the road were subsequently found to have more than the legal limit of alcohol in their blood (0.08%).

About one third of drivers killed in accidents were found on autopsy to have been indulging to excess.

Mr Rodgers said at a press conference to announce the new campaign: "We have got to get over to people that road accidents are shocking. We have got to get over to the young man drinking with his girl friend, that by the end of the evening she could be disfigured if he drives."

The minister said it was the obligation of everyone to recognize that drinking and driving do not mix.

Meanwhile, the emphasis of the department of health and social security, under Mr Ennals, is clearly going to be based on health education along the lines currently being tried by a high-powered campaign in the North-east of England (**The Journal** December).

To the disappointment of some campaigners, however, the health minister is not showing much enthusiasm for some of the more controversial proposals made by MPs in the social services and employment sub-committee of the expenditure committee of the House of Commons earlier this year.

The committee wanted to devote a larger proportion of the revenue deriving from the sale of alcohol to health education.

But the government (in its White Paper statement of policy *Prevention and Health* * published just before Christmas) says such a proposal "would represent a major departure from the principles which have governed the distribution of tax revenue in this country." The government, it says, must have the flexibility to allocate resources in the light of changing needs and priorities.

The sub-committee also recommended that the price of alcoholic drink should not be allowed to fall in real terms relative to prices or incomes.

(In the period 1970 to 1976, the average price of alcohol relative to the general movement of prices fell by 4% for beer, 14% for wine, and 21% for spirits while real per capita disposable income increased by 17%.)

The White Paper said the government recognized the importance of price in raising or moderating overall demand for drink and appreciated that alcohol-related harm was more likely to increase when the total amount of alcohol being consumed was rising rather than when it was stable.

"The recommendation would of course, involve difficulties both of principle and of practice," the White Paper goes on.

"However, the general implications for the government's fiscal, industrial, counter-inflation, and social policies would have to be taken into account as would also international considerations.

"Moreover, it might be regarded as unreasonable to penalize the great majority of people who drink without harm in the hope of deterring the minority whose drinking does or might cause harm to themselves or others.

"These issues will require careful consideration before the government can reach a final decision. Health ministers (for England and Wales and for Scotland) wish to encourage public debate on these issues and this is the main purpose of the proposed consultative document (a document to be issued later this year on various possible strategies against alcoholism)."

The fact debate has already begun within the government, is illustrated by the appearance in the international science journal *Nature* (Vol 270 Dec 15) of a major study, Three Centuries of Alcohol in the British Diet, by Josephine A. Spring and David H. Buss of the ministry of agriculture, fisheries and food, London.

The study shows alcoholic drinks were consumed in larger quantities in the 18th and 19th centuries than in the 20th, although there has been a recent increase from the historical low of 1930-60.

The study notes also that beer, spirits, and wines once provided about 500 kcal per person per day, compared to 160 kcal in 1975, towards the average energy requirement of the total population.

"Beer has always contributed most to the alcohol, energy, and nutrient content of the diet, although its importance relative to spirits and wine has declined," the authors add.

*** Prevention and Health (Department of Health and Social Security, Department of Education and Science, Scottish Office, Welsh Office). Published as Command 7047 by Her Majesty's Stationery Office. Price £1.60 net.**

Bureaucrats shun elderly alcoholics

PALM BEACH GARDENS — Too many bureaucrats are wanting to avoid the problem of alcoholism among the elderly, an aide to Claude Pepper, chairman of the select committee on aging of the United States house of representatives, said here.

Non-government agencies doing excellent work with elderly alcoholics are universally short of funds, John F. Tischler told a seminar on alcoholism and the elderly.

"Too often these people (bureaucrats) seem to have the attitude that elderly alcoholics aren't hurting anybody. They seem to be saying: 'If they choose to live in an alcoholic haze, why take it away from them?' "

While the national sector in Washington appears to be lukewarm, he said, other sectors — private, semi-private, church, community, or state-sponsored, are doing excellent work but without funds.

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) is an exception to Washington indifference, Mr Tischler said.

He said at a meeting between Ernest Noble, NIAAA director, and Congressman Pepper, Dr Noble pointed out that twice as much money is allocated to fighting drug traffic as is provided for alcoholism, although alcoholics outnumber drug users 10 to one. Dr Noble urged the congressman to use his influence and his committee to ensure the fight against alcoholism gets a better share of funds. "I agree with Dr Noble that we need much more funding for our efforts . . . and Congressman Pepper pledged his efforts to that end."

Mr Tischler said young people have many incentives to restrain them from alcoholism — jobs, family responsibilities, future health, and keeping their marriages together. But, the incentives tend to work the opposite way for the elderly.

The elderly drink because of loneliness, low self-esteem, boredom, and "unprotectedness." The job of retirement is to learn to live as a nobody, and even people who weren't heavy drinkers during their working years, can easily become addicted in their old age, he said.

Although there isn't much legislative activity in Washington on alcohol abuse, NIAAA has developed a five-year program that holds a great deal of promise, Mr Tischler said. Commitments to support it have been received from the leaders of a number of national organizations, including the National Council on Aging, Inc, and the National Council of Senior Citizens.

The plan has three major goals to be accomplished by 1983. One is to reduce the prevalence of alcohol-associated problems by encouraging and assisting state and local governments, as well as voluntary organizations, to devote more of their resources to these problems.

A second broad goal is to increase national alcoholism treatment capability from 600,000 to 1.2 million people. The third is to double the national resources for alcohol research.

Referring to four highly successful alcoholism programs he'd visited in different parts of the country, Mr Tischler said they seem to overlook an important segment of the elderly alcoholic population: "Relatively untouched is the little housewife who is nipping all day at the bottle she has hidden in the kitchen cabinet and who presents, at least for a while, a picture of sobriety when her family returns home in the evening. Or the officer's widow, or the divorced retiree, who takes a sip before going out with the girls, and sips again while playing cards, and again before dinner, and again before going to bed."



John Tischler

He suggested funds could be obtained from a special surtax on liquor, wines, and beer. If they were, he said, he'd like to see them spent on a flank attack on alcoholism. For the moment, he said, many research projects on the aging are impractical and wasteful.

The worthwhile programs are those geared to the needs and capabilities of senior citizens, in which capable ones help those unable to help themselves — programs such as Meals on Wheels, Foster Grandparents, Home Health Aides, and Senior Companions.

Mr Tischler suggested it might prove worthwhile to bring together, into one package, the thrusts of Congressman Pepper's select committee on aging, and of the people involved in the fight against alcoholism. The main thrust of the committee is to provide for the frail elderly so they won't have to be institutionalized.

Pipes, cigar plane ban

WASHINGTON — Smoking of pipes and cigars on United States commercial airliners is to be banned by the Civil Aeronautics Board.

In addition, the board has asked for public comment on three additional possibilities: banning all smoking on small aircraft; banning all smoking on short flights; or a total ban on smoking on all aircraft.

For entrepreneurs: fast money in navel gazing

By Wayne Howell



My Dearest Son:

Alas, I am no Lord Chesterfield and thus this letter will be somewhat lacking in the wit and charm that made his letters to his son so justly famous. But my lack of literary flair notwithstanding, I feel it is my duty as a father to pass on to you what wisdom I possess on the subject of getting ahead in this world — and staying ahead.

Two decades ago, I would have advised you to apply your talents in such a manner so as to obtain a fast-food franchise operation: a small aggregate of Big Mac establishments in suitable suburban locations is, at the present time, the key to many a prescient (circa 1955) young man's fortune. And one decade ago, I would have advised you to concentrate your energies on the mass merchandising of sports equipment: many able young men have ridden the wave of the jock-revolution into very snug financial harbors.

But now, after due consideration, I feel that you would be wiser to eschew the commercial marketplace. Now is the time to get into Spas. Spas of a special sort — it is an age of specialization my son. Diet spas? A young man could make his marks (when you start raking it in, it is only prudent to convert it into a stable currency) with counselling and cottage cheese at $400 a week. Self-awareness seminars (talky-talkies and/or touchy-feelies) in a pastoral setting? A rustic retreat where one can work on one's backhand and loh? Passing fads my son.

Prudence dictates that you get into something lasting. And that is why I suggest a spa for the treatment of persons with drinking problems.

The first thing you will need is a degree in the social sciences, preferably a doctorate. This need not take an inordinate amount of time or effort, for there can be found institutions of a decidedly sectarian character that tend to confer these august degrees without a lot of fuss and bother. The second thing you will need is a line of credit sufficient to allow you to make a down payment on a suitably imposing country estate.

Once your 'institute' has been incorporated, you are in business. Set to work developing your unique therapeutic approach: it really doesn't matter what it is — just scrounge around in some of your old college texts and come up with a new angle on birth trauma, a new behaviorist twist, or a rehash of some of Wilhelm Reich's ideas (no one ever went broke peddling the ideas of Wilhelm Reich to the gullible). Anything at all, as long as it has a little sex-appeal from the PR point of view.

Establish a fee schedule, making sure that the fees are outrageous enough to impress your prospective clients with the superior efficacy of your methods. Then advertise discreetly in the appropriate publications — the ones read by the kind of persons who can afford your unique therapeutic milieu: this kind of experience is not for the common herd, who wouldn't be able to appreciate it anyway. Guarantee cures, although be sure to explain that abstinence is passé, the Dry Look is definitely out, the Damp Look (controlled drinking) is the in thing.

As far as treatment goes, just make sure you hire staff who encourage the clients to sit around in small groups and talk about themselves a lot: they will all love to do that, and the more they pay for the privilege of doing it, the more they will believe in the uniqueness of the therapeutic experience you are providing for them. Maintain high standards in the kitchens, and make sure that there are adequate facilities for recreation so if perchance the clients get bored with communal navel gazing they can amuse themselves with swimming, golf, or tennis. Keep it sophisticated and genteel, and I predict the carriage trade will beat a path to your door.

This is the best advice I can give you son. Do not be discouraged by the fact that a few institutions such as I have described already exist. Your task is to go them one better.

With all my best wishes,
Dad

* * *

(Wayne Howell is an Ottawa physician and freelance writer).



Canadian cannabis laws

Change is no vote-getter...

By John Shaughnessy

TORONTO — Enforcement of Canada's cannabis laws may become stricter before it becomes more lenient, according to a Toronto criminal lawyer.

David Doney told a meeting here of the National Organization for the Reform of Marijuana Laws of Canada — NORML (Canada) — he suspects that as society grows more and more conservative, the intransigence of the government (with respect to changing the laws) may become greater, and the penalties imposed by the courts may also become greater.

He said he believes this will be the case "even in the face of increased public use of cannabis, and even in the face of increased numbers of people who are brought before the courts on marijuana related charges."

Contrary to the image in the popular press that the battle against harsh treatment of marijuana users is largely over, Mr Doney said the courts and the police are still enforcing the laws, and users are still going to jail, particularly those charged for repeat offences.

And he doesn't see much indication the law is going to be changed.

"From what I can see, the cannabis legislation is not an issue that will produce votes for the government. In fact, a change in the laws might cost votes and the government is not going to risk that."

Mr Doney, who has acted as counsel for NORML (Canada), said the group that's pushing for changes in these laws is very small and without much strength. NORML (Canada) has about 600 members.

Vancouver's criminal lawyers have recently come out in favor of decriminalizing marijuana, but Mr Doney is skeptical that this will have much impact. Although the government does listen to the legal profession, he said most members of the bar are conservative, and the chances of getting all of Canada's lawyers to push for changes in the cannabis legislation are slim.

...And public is cold toward reform

TORONTO — Groups seeking to change Canada's marijuana laws face an uphill struggle.

Despite large increases in marijuana use and in the number of users in recent years, campaigns such as those favoring decriminalization of cannabis do not have the support of the Canadian public.

Federal statistics indicate arrests and conviction on marijuana offences rose from 144 in 1966 to 33,281 last year, but a survey conducted by *Weekend Magazine*, and published last December, indicates most Canadians believe it would be a bad thing to legalize marijuana.

In the survey, 1,061 people in 32 of the country's largest urban centres were asked if they think marijuana should be legalized. Sixty-one per cent said it would be a bad thing to do, while 33% thought it would be a good thing.

Twenty-eight per cent of the respondents described marijuana use as a very serious problem in Canada, and another 26% think it is a somewhat serious problem. Only 20% said it was not a problem.

When asked whether marijuana use leads to the use of dangerous hard drugs, 23% of the respondents answered almost always, 38% said frequently, 16% said seldom, and 17% almost never. Thirty-three per cent of the respondents think marijuana is more harmful than alcohol, 34% think it is equally harmful, and 27% think it is less harmful.

Most respondents think marijuana users are just like other people. When asked to rate marijuana users on a scale from 1 ("like anyone else") to 7 ("a sick criminal element", 50% chose 1 and 2, while 13% chose 6 and 7.

More women than men view marijuana use as a very serious, or somewhat serious, social problem (61% compared with 47%), and they also have a more negative perception of marijuana users. Women gave marijuana users an average rating of 3.02 on the scale describing them as "like anyone else" to "sick criminal". The average rating given by men was 2.74. Sixty-four per cent of women consider legalizing marijuana would be a bad thing, while 57% of men think so.

Negative attitudes towards marijuana increased with age, according to the survey. Among those 24 or under, 43% think legalization is a somewhat or very good thing. Only 26% of those 55 and over agree. Thirty-eight percent of the oldest age group said marijuana use represents a very serious social problem compared with 21% of the youngest age group. The oldest age group gave marijuana users an average rating of 3.54, compared to 2.32 by the youngest age group.

Geographically, residents of the Atlantic and Quebec regions were found to be least favorable to legalization of marijuana — 29% and 34% respectively think it would be a somewhat or very good thing. In Ontario, the proportion in favor is 40%, in British Columbia 41%, and on the Prairies 43%. Fewer people from British Columbia and Ontario feel marijuana use almost always leads to hard drugs, while more residents of the Atlantic region and Quebec hold this view.

Among English-speaking Canadians, 36% feel it would be a very good thing to legalize marijuana. Twenty-seven per cent of French-speaking Canadians share this view. However, more than twice as many French-speaking Canadians as English-speaking Canadians view marijuana use as a very serious social problem (50% compared with 23%). Twenty-eight per cent of French Canadians consider marijuana much more harmful than alcohol, and 38% think it leads to use of hard drugs. The comparative figures for English Canadians were 11% and 20%.

The French Canadians gave marijuana users an average rating of 3.49 compared to a more positive average rating of 2.74 given by English Canadians.

Vancouver lawyers push for revisions

VANCOUVER — Vancouver's criminal lawyers have officially endorsed the decriminalization of marijuana.

At a meeting held late last year, the Vancouver criminal justice section of the Canadian Bar Association's British Columbia branch overwhelmingly passed a resolution calling for the decriminalization of simple possession and cultivation of cannabis for one's own use, and the non-profit transfer of small amounts between users.

The resolution asked also that cannabis be removed from the Narcotic Control Act and be placed in Schedule G of the Food and Drugs Act (which deals with such drugs as amphetamines, barbituric acid, and methaqualone).

According to Peter C. Ritchie, acting vice chairman of the section, the meeting was well attended, and there was surprisingly little debate on the motion. He said no precise count of votes was taken, but 55 people were in attendance, and there was only one vote against the motion and very few who abstained.

The resolution was drafted and proposed by Ted Siefred, a Vancouver criminal lawyer and a director of the National Organization for the Reform of Marijuana Laws (NORML) (Canada). According to Mr. Ritchie, Mr Siefred will seek to get the resolution similarly endorsed by the two other criminal justice sections of the Canadian Bar Association's BC branch, criminal justice subsections in other provinces, the national criminal justice subsection of the CBA, and ultimately by the CBA as a whole. The final goal is to get the CBA officially to urge the Canadian Senate and House of Commons to give effect to the resolution by transferring legal control of cannabis to Schedule G of the Food and Drugs Act and introducing other appropriate amendments as recommended by the LeDain commission.

The Vancouver criminal lawyers are the first such group in Canada to come out publicly in favor of the decriminalization of simple possession of marijuana, and the voting on the resolution indicates there was strong support from both prosecutors and defence lawyers.

'It's not an all-out endorsement of complete legalization . . .'

The resolution, however, did not specify any alternate methods of regulating cannabis. Mr. Ritchie said: "I think the approach being taken by NORML, and the step that the subsection was prepared to take, was towards decriminalization. It's a sizeable step from my point of view, but it's not an all-out endorsement of complete legalization."

'Legal controls on heroin are also drawing the attention of BC criminal lawyers . . .'

Legal controls on heroin are also drawing the attention of BC's criminal lawyers. Mr Ritchie said representatives from various provincial government agencies attended his section's last meeting and presented the government's proposals concerning mandatory treatment for heroin addiction "in light of legislation that's to come into effect a year or so hence."

He said the proposals spurred a very heated debate — unlike the marijuana resolution — but very little was resolved, and the section has taken no official stance with respect to legal controls on heroin.

"Most at the meeting felt the government still had a lot of loose ends to deal with," said Mr. Ritchie.

In the US, researcher warns:

Many health doubts remain

WASHINGTON — Many of the unanswered questions about the health consequences of marijuana use cannot simply be ignored, believes Robert Petersen, of the United States National Institute on Drug Abuse.

Those who argue that marijuana is without significant harm, and this is based on severely limited data, are acting in an irresponsible way, Dr Petersen told the annual conference here of the National Organization for the Reform of the Marijuana Laws (NORML).

Dr Petersen pointed out that most American research experience "has been confined to relatively small amounts, of low potency, and used by the healthiest of the population for a limited period of time.

"To talk about the future, long range, health implications of that is a bit like trying to predict the future of alcohol use in a society where there has been mainly use of a recently introduced 3.2% beer, over a short period of time."

'It is simply not true people impaired by marijuana will abstain from driving . . .'

Dr Petersen said the decriminalization of marijuana use in California was a wise social policy move, but with certain unhappy public health consequences. The main one is the driving done under the influence of marijuana.

The effects on highway safety can only be estimated, "but it is simply not true that people, knowing they are impaired by marijuana, will abstain from driving any more than those who realize full well the effects of alcohol," Dr Petersen said.

Dr Petersen said there are several major areas where the implications of regular cannabis use are still unknown.

An important one is the use by adolescents, "especially those who are experiencing more than the usual difficulties in achieving a psychological identity or acquiring the necessary social and intellectual skills."

Also, "the concern of minority leaders that marijuana use may be more insidious to members of their group than for the highly motivated members of the majority, may have a basis in fact which should be examined carefully."

Very little is known also about the use of marijuana by those who are not in good health.

Dr Petersen said a more consistent policy is needed regarding the use of all recreational drugs.

Poor catch at border

WASHINGTON — Significant quantities of heroin and cocaine coming across the United States-Mexican border are not intercepted because of a lack of coordination among various agencies, a government report charges.

The border is, in reality, a "revolving door," claims the survey by the General Accounting Office.

It estimates the Drug Enforcement Administration, the Customs Service, and the Immigration and Naturalization Service, capture only some 6% of the heroin imported from Mexico. In the main, only small time operators are caught and there is little identification of major traffickers or networks.

The report suggests the government consider consolidation of the agencies into one force for the 2,000 mile border.

AA aids NZ

AUCKLAND, NZ —Between 55% and 60% of alcoholics stop drinking within one month of attending their first Alcoholics Anonymous meeting, according to an AA survey in New Zealand. A further 15% stop within a year.

Of more than 700 members who replied to a questionnaire, 56% had been without a drink for a year or more.

A lower success rate has been reported by a Salvation Army inpatient clinic. A review of its first five years showed that 40% of the 348 male alcoholics who began treatment completed the three-month course and left sober.



Georges L. Pequignot and Werner Lelbach (centre), are the 1977 E. M. Jellinek award recipients. With them are Archer Tongue (left), director of the International Council on Alcohol and Addictions, and David Archibald, executive vice-chairman of the Addiction Research Foundation of Ontario.

Two win Jellinek award

TORONTO — Two research scientists — one in Germany and one in France — are the joint recipients of the annual E. M. Jellinek Memorial Award for work in clinical epidemiology.

Werner K. Lelbach, head, gastroenterologic unit, department of internal medicine, Bonn, Germany, and Georges L. Pequignot, director of research, National Institute of Health and Medical Research, Paris, France, were presented with their awards during ceremonies in November 1977, designating the Addiction Research Foundation of Ontario as a World Health Organization collaborating centre.

Dr Lelbach's research interests in internal medicine have been mainly in the field of gastroenterology, and have included the study of quantitative correlation in alcoholic liver disease, and the hepatologic aspects of vinyl chloride disease.

Dr Lelbach received his doctor of medicine degree from the University of Bonn in 1952. He was trained in pathologic anatomy and histology while working under Wilhelm Ceelen and Herwig Hamperl at the Institute of Pathology in Bonn. During this period, Dr Lelbach completed a treatise on the histomorphology of radiation effects in malignant tumors.

Dr Pequignot has specialized in gastroenterology and nutrition since obtaining his medical degree in 1945. His research has focused primarily in three areas; on food consumption, therapeutic dietetics and hospital food services, and epidemiological investigations.

Dr Pequignot's research and findings have appeared in more than 120 articles published in scientific and professional journals since 1948.

The E.M. Jellinek Award is an international award made to scientists and scholars who make important contributions to the advancement of knowledge in the field of alcohol-related problems. The award consists of a bronze casting of the head of Dr Jellinek, and $1,000.

Dr Jellinek was one of the founding fathers of the scientific approach to studying alcohol-related problems, as well as a prime mover in the humanitarian approach to their alleviation.

Each year, the directors of the Jellinek Memorial Fund, who represent organizations which Dr Jellinek helped found, select the award recipient(s) from names suggested by various organizations around the world.

Wine and spirit sales continue to rise

(from page 1)

fray with a legal "light" beer, possibly by the beginning of February. The Carling brand was to have no more than 2.5% alcohol.

Molson's Brewery (Ontario) Ltd indicated it would watch the scene to see how consumers respond. The company's own surveys had shown minimal interest in the light beers.

But why all the interest in low-alcohol beers, especially since the major brewers have been marketing a "low-alcohol" beer in Alberta, Manitoba, and Saskatchewan for some time? (The beer, known locally as "lo-ball" beer, has about 3.9% alcohol, and in Alberta, at least, it is subsidized by the provincial government.)

The key to the riddle can be found in beer-town, USA, Milwaukee, where Miller Brewing Co managed a marketing miracle when it gained 40% increases in sales for its "Miller's Lite" beer while other traditional beers were having trouble maintaining their own against inroads by wines and hard liquors.

In Canada, despite a significant growth in beer drinking at the start of the decade, beer sales have seen a steady drop in growth and, most recently, an actual decline (about 0.2%) in 1976 and a slightly higher decline in 1977.

Meanwhile, all indications are that spirits and wines, particularly imported wines, have continued to grab more Canadian drinkers — a trend that worries both domestic brewers and government officials concerned with alcoholism.

In the United States, some of the low-alcohol and low-calorie beers are selling at a premium; here in Canada, it is assumed by the brewers that they would sell at the same price as regular beers, due to the provincially-controlled distribution systems.

Interestingly enough, some of the beer companies are somewhat non-plussed that the federal regulations don't, in fact, offer an incentive to market the lower alcohol content beers. (The provincial governments do, through a subsidy that allows "lo-ball" beers to be sold at a slightly lower price in Alberta, Saskatchewan, and Manitoba).

The big question among marketing experts is whether lighter beers will attract new beer drinkers or merely lead to an adjustment amongst existing beer drinkers. (In the latter case, a major purpose would be thwarted; that is, picking up wine and spirit drinkers).

In fact, the beer companies suspect the effect will be both additive and substitutive.

One question obviously not being asked in marketing circles, and perhaps in other circles as well, is whether light beers — especially ones advertised with the emphasis on low-calories — may finally attract non-drinkers to beer drinking, thereby leading to an increase in alcohol use rather than a decrease.

(The calories must be reduced by 50% or more for companies to advertise their products as calorie-reduced, according to the federal regulations.)

The answers to all of these questions, and others, will come in the next few months, when the "light" beers stand or fall in the marketplace.

Experts flock to defend Dr Mandell

LOS ANGELES — A defence fund for Arnold Mandell, who prescribed amphetamines in treatment of amphetamine-dependent members of the San Diego Chargers football team, has been formed by a battery of leading psychiatrists and psychopharmacologists.

Dr Mandell, professor of psychiatry at the University of California, San Diego, was found guilty in November by the California board of medical quality for excessive amphetamine prescribing.

Thomas Ungerleider, associate professor of psychiatry at the University of California, Los Angeles, said a main objective in Dr Mandell's appeal is to challenge the emphasis placed at the hearing on the Physician's Desk Reference (PDR) as a arbiter in prescribing practice. (**The Journal**, Nov, 1977).

He pointed out Dr Mandell has lost, for five years, the right to write prescriptions for controlled substances, and has suffered a severe financial loss in fighting his case.

"He is a very depressed individual who really didn't believe, if you are right, something like this could happen. Many of us didn't either."

None of the football players Dr Mandell treated testified against him at the hearing.

CAF budget deficit forces a retrenchment

(from page 1)

Its grant from the Non-Medical Use of Drugs Directorate (Non-Mud) for the 1978/79 fiscal year will be slashed by half — from $100,000 for the current fiscal year, to about $50,000 the following year, according to Mr Burke.

With membership fees, the prospect of donations from big business and industry, and the possibility of an additional grant from another branch of the federal government, Mr Burke hopes to reach an $85,000 to $90,000 operating budget for 1978/79.

"I've got a battle on my hands trying to balance the budget this year," he said.

"The board would like to make better use of the monies, and I feel the members of the board, as well as members at large, can contribute a great deal of organizational support at their own regional levels. So, we don't need half a dozen or more people in the central office."



Dennis Taylor was the first executive director of the CAF.

Mr Burke squelched rumors the CAF was "going down the drain. We are stabilizing it, retrenching a little. But it's time for retrenchment for a lot of organizations. It's time to look at the way you're spending your money, and make sure that it's spent effectively."

He emphasized the need for a major campaign to solicit more memberships for the CAF — a campaign that has been mounted in a small way since he took office, and one with which he said he is neither satisfied nor dissatisfied.

(In 1976, there were nearly 600 members in the CAF, according to Ms Kipp. Two hundred people did not renew their memberships, but 200 new members have joined this year — bringing the membership total back to nearly 600).

Ms Berthiaume, who launched several fund-raising projects during her term, said some efforts are beginning to show some success, but not enough to offset the impending budget deficit.

As for the future, Mr Burke said: "I think if the organization is going to really be part of the total community, and not just an inbred thing — for the most part that's what it's been, an organization to sponsor conferences once a year — if it's to expose itself to the broader community, then maybe some of the board members should be from the community at large."

He said he wanted to talk to the membership about the possibility of a small percentage of the board being made up of people who aren't associated with the alcohol and drug field but rather with business and industry.

"Occupational alcoholism is big business, so why shouldn't we have big business on the board?" Mr Burke asked.

He said the CAF's regional programs must be strong if the organization is to be successful.

"We're going all out to try and develop five regional programs, even if that means five little conferences across the country. Let the things that are important to the regions happen first, and the central office will benefit from it.

"One of the thoughts I have is maybe the annual conference should be only every two years, and then, on alternate years, we ought to have regional conferences."

The CAF's 13th annual conference, to be held in Calgary, Alberta, in September, will go on as scheduled, he added.

Skid row: Lysol is 'in-thing'

WINNIPEG — Winnipeg police have warned that the theft of a quantity of Lysol disinfectant in December, 1977, is an indication the liquid has replaced after-shave lotions, vanilla extract, and strained shoe polish as one of the last-resort drinks on Winnipeg's Skid Row.

And to back up the warning, police and some social agencies in the city's skid row area report that containers of Lysol have recently been found in alleyways frequented by down-and-outers with liquor problems. The cans, without exception, are empty.

"Lysol now appears to be the in-thing," a Winnipeg police spokesman said. He added police may have to ask retailers to keep an eye on who is buying Lysol.

A Winnipeg physician involved in the treatment and care of alcoholics said it is no wonder the core area residents are turning to Lysol "because chemically it would really zonk your head, I suppose."

The down-and-outers punch a hole through the bottom of the spray cans to let out the compression and catch the liquid as it drains from the can to drink it.

"They probably have the cleanest innards of anyone around," Provincial Magistrate G. C. Parking said.

Ross Ramsey, director of program development and coordination for the Alcoholism Foundation of Manitoba, told **The Journal** his agency has recently become aware of the new substance of last resort on Winnipeg's skid row, but has not actually been faced with victims of ill effects from Lysol.

Mr Ramsey said the AFM now is in the process of gathering medical information on the effects of Lysol on the human constitution and long-term or permanent side effects for people drinking a little, or a lot, of the cleaning fluid.

As well, the AFM is finding out from poison control centres just how to counteract Lysol.

"Once we have all the information we need, we'll set up an approach to this new problem," Mr Ramsay said.

Afghans get Danish aid

GENEVA — The Danish government is to make available $397,290 of its development aid funds for a project of health care aimed at the prevention and treatment of drug dependence in Afghanistan.

The project will be executed by the United Nations Fund for Drug Abuse Control in collaboration with the World Health Organization.

Denmark thus follows Norway in a major Nordic initiative to deploy development aid funds in the fight against drug abuse. Norway's contribution of $5.4m to the UN fund is widely expected to be followed by all members of the Nordic Council.

Early teens are toughened up not to smoke

MIAMI BEACH — Seventh graders are at an age when they can be easily persuaded by peer pressure, smoking parents, and advertising, to start smoking. But it is possible to toughen them up so they can withstand these blandishments.

The way to do this, according to Richard I. Evans, is not to tell them they'll die of lung cancer in 40 years. Rather, it's to tell them about the immediate bad effects of smoking on a seventh grader's health, he told the annual convention here of the American Heart Association.

"It is evident children do believe the traditional health education message that smoking is dangerous to their long-term health", Dr Evans, professor of psychology, University of Houston, said.

"Despite this knowledge, three sources of social pressure appear to have a more immediate and overriding influence on many children to begin smoking. These are peers, the models of smoking parents, and the media.

"Therefore, in the present study, films and other materials were designed to familiarize children with the nature of these particular pressures to smoke, and to train them to cope with these pressures."

Information given to the children also included the immediate adverse physiologic effects of smoking. This was aided by doing mass spectrometric analysis of saliva specimens for nicotine content as a pretest to correlate with self-reports of smoking.

Children in 10 Houston, public junior high schools were then assigned to three treatment groups and one control group. The 750 children were in the program for 10 weeks.

In the full-treatment group, the children saw four videotapes dealing with the immediate physiologic effects of smoking, social pressures to smoke, and ways of combatting these pressures. After, they took part in training sessions in how to cope with pressures. They also had three tests which were accompanied by feedback based on the results of earlier tests, he said.

A second group had a pretest first, as the first group did, plus feedback on their smoking behavior, and three followup tests. A third comparison group had exposure to the videotape about the nicotine in saliva of smokers, one pretest, and three post-tests. The control group had only a single before-and-after test.

The number of children who started to smoke was significantly lower in all three of the treatment groups. (9.6%, versus 18.3%, overall). He said the results "suggest such interventions may prove more useful than merely instructing them in the long term dangers of smoking."

Dr Evans said plans are now to follow students through the eighth and ninth grades. The study being conducted by psychologists from the University of Houston is being done in cooperation with Baylor College of Medicine's National Heart and Blood Vessel Research and Demonstration Center.

Prison system promotes 'excess use of drugs'

(from page 1)

limitations on the practices of health care officers who dispensed symptomatic medications of various kinds and there were inadequate limitations regarding tranquillizers.

"Pill parades" for the distribution of medications were held in nearly all institutions, usually three or four times a day; 10 institutions reported four parades daily, seven reported three parades daily, and one reported a daily pill parade. Other institutions said pill parades were held on an irregular basis.

According to the committee, attendance at pill parade was high, and a substantial proportion of inmates, including repeaters, attended at some time during the day. The extreme range in the percentage of the inmate population attending pill parade — at Dorchester 74.5%; at the Archambault Institution 1.5% — indicated to the committee that there was no policy guiding the institutional health services in the use of drugs.

At the Prison for Women (in Kingston) it was reported that the average daily attendance of women inmates for whom drugs were prescribed was 116.4% of those in custody.

The committee found in some institutions, from one-third to one-half of the inmate population was receiving some form of medication. (See chart below). This, it said, appeared inconsistent with the fact that a high percentage of the inmate population are males under 40 years of age — an age group which experiences a relatively low incidence of disease and which generally makes relatively fewer demands on medical services in civilian life.

According to the committee, medications served many purposes in the correctional institutions in addition to their stated therapeutic role, and "the campaign for medications by some inmates for secondary gain (drugs have the same status as currency) truly tested the resources of the health care centre."

In some institutions, large carts and trays of medications were wheeled to a highly visible central distribution point. Medications were picked up by inmates on their way to or from some other activity. Inmates, other than those for whom prescriptions had been written, stopped by the cart to request a wide variety of items such as antacids, cough syrup, laxatives, aspirin, "292s," sedatives, and tranquillizers. These were often stocked routinely on the medication cart.

Symptomatic drug treatment was sought by inmates for headache, backache, sore shoulders, gastrointestinal complaints, and a variety of others.

"Health care officers and nurses frequently were allowed, and observed, to respond by dispensing these and other types of medications, including controlled drugs," said the report. "It was also noted that many of the prescription medications prepared for distribution were not picked up by inmates."

The committee concluded that in the absence of medical direction, and of appropriate staff supervision, health care officers had acquiesced to the pressures inherent in the penitentiary environment. "The system promoted excessive and inappropriate use of drugs and often encouraged exploitation of staff and medications. In addition, it further encouraged inappropriate patterns for inmates to deal with health concerns. Through successful exploitation, inmates also lost confidence in the health services."

As a result of its findings, the committee made eight recommendations:

- That top priority be given to the development of a policy concerning the use and distribution of medications.
- That the use of symptomatic medication be drastically curtailed by limiting it to those cases where there is convincing evidence of patient need.
- That all prescriptions be for a specific period of time, which will be no longer than medically necessary and shorter than in civilian life; that all patients on long-term medication be regularly reviewed in terms of their need to continue the medication; and that renewal of prescriptions require the signature of a physician.
- That no drug other than acetylsalicylic acid (ASA) be dispensed to inmates save as a result of a physician's specific prescription, or in the event of an emergency, and that standing orders shall not be permitted which authorize health care officers to dispense drugs, especially controlled drugs.
- That the Medical and Health Services Branch constantly monitor drug use and investigate and remedy those situations where drug use is significantly higher than the expected average.
- That no request by a patient for hypnotic or sedative medication be prescribed by the institutional physician without a search for evidence that the patient's sleep is disturbed, in reports from correctional officers, nurses, or health care officers.
- That large carts and trays of drugs and medications in a highly visible central distribution point should be abolished.
- That pharmacists' services be extended to those regions where they do not exist to control the purchase, storage and dispensing of drugs.

Dr Craigen said that in the two years since the report was adopted, most of the committee's recommendations have been implemented. A policy manual has been developed and distributed to the field, and a monitoring system has been set up.

'A new information system will give us data on the drugs used in each penal institution . . .'

"Up until the latter part of last year, our monitoring hasn't been good. But even prior to that I knew that in some institutions, such as Dorchester, there had been quite a dramatic decrease in drug use because the message got through to physicians to start controlling it," said Dr Draigen.

"Last December, (1977) we put an information system into position which will give us data on the drugs used in each institution, and we should start to get returns on that next month."

The recommendations concerning symptomatic medication, and the length of physicians prescriptions have been implemented; the recommendation concerning hypnotics and sedatives has been partially implemented and will be discussed at a March meeting of the senior medical staff of the Canadian Penitentiary Service (CPS) with a view to full implementation.

The abolition of central drug carts and trays will soon be tried in medium security institutions. "If we can manage it there, we'll go on to maximum institutions," said Dr Draigen.

Pharmacists' services have been extended in the Ontario and Quebec regions, and a pharmacist on contract at CPS headquarters is studying the possibility of further extension.

Only the recommendation concerning ASA has been rejected. Dr Craigen said his senior medical staff felt that, in its wording, it was unduly limiting the physician's freedom to prescribe. However, he said standard guidelines have been issued which increase control of drugs.

"We are re-convening a smaller committee made up of some of the members who issued the 1975 report and one or two new members," said Dr Craigen. "They will meet this month and one of their jobs will be to study the implementation of their own recommendations.

"We agreed to do this when the original committee was dissolved in 1975, and that may have been a spur for me to get cracking and implement all of the recommendations."

- ILLUSTRATIVE DATA RE DRUGS DISPENSED IN C.P.S. INSTITUTIONS - ONTARIO REGION, JAN.-MAR. 1975

Inmates, Patients and Drugs Dispensed

ITEM	Millhaven Inst.	Millhaven Bath	R.P.C.[1] (Ont.)	Joyceville & Pittsburgh	Warkworth	Prison for Women
Ave. Inmate Pop.	294	72	330	502	418	127
Medication Line[2]						
Total Attendance	38350	8680	6992	8251	12691	22715[3]
Drugs Dispensed[2]						
No. of patients	546	145	1126	-	2683	168
Drug Category:						
Antibiotics	150	49	1092	23800	2246	62
Analgesics	310	65	1536	40100	1435	123
Psychotropics	467	84	0	4950	2371	506
Sedatives	459	46	278	10320	283	151
Anti-inflammatory	100	66	583	22760	251	7
Anti-convulsants	50	0	608	2440	2578	28
Others	7	4	-	3750	3527	259
TOTAL	1543	314	4097	108120	12691	1136
Percentage Distribution of Drugs Dispensed by Category of Drug						
Antibiotics	9.72	15.61	26.65	22.01	17.70	5.46
Analgesics	20.09	20.70	37.49	37.09	11.31	10.83
Psychotropics	30.27	26.75	-	4.58	18.68	44.54
Sedatives	29.75	14.65	6.79	9.54	2.23	13.29
Anti-inflammatory	6.48	21.02	14.23	21.05	1.98	0.62
Anti-convulsant	3.24	-	14.84	2.26	20.31	2.46
Others	0.45	1.27	-	3.47	27.79	22.80
TOTAL	100.00	100.00	100.00	100.00	100.00	100.00

[1] Formerly known as the Regional Medical Centre.

[2] Extracts from Procedure for Reports:
- Drugs dispensed - "number of patients: report number of different patients treated and itemzied drugs received by category".
- Medication Line - "multiply the total number of patients by the number of times they received medication".

[3] Total Medications, not attendance.

Source: Health Services Quarterly Reports, Ontario Region, January-March 1975.

EDITOR
Anne MacLennan

STAFF WRITER/PRODUCTION EDITOR
Karin Pargas

CONTRIBUTING EDITORS
Harvey McConnell (Washington)
John Shaughnessy (Toronto)

SCIENCE EDITOR
Dr Ruth Segal

The Journal
Published by Addiction Research Foundation of Ontario
33 Russell St, Toronto, (416) 595-6053

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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Comment

Cocaine for the rich is robbing the poor

By Harvey McConnell

The Swede was the last to join the collective taxi before it left El Alto airport to drop 1,000 feet down the mountain to the bowl that is La Paz, Bolivia. Fashionably booted and jeaned, he complained in excellent English, about effects of altitude (La Paz is at 13,500 feet in the Andes), and was happy he was only there a couple of days "to buy Indian handicrafts."

The taxi wound through the makeshift hovels of the barrios marginale, slum homes for tens of thousands of Incas which cling to the mountainside, into the ordinary slums of the Indian quarter. With rucksack on his back, the Swedish visitor disappeared into the entrance of the modest Hotel de los Andes.

Natural and unremarkable to anyone who does not know where, or how, to obtain cocaine. To those who do, and it does not take long to find out, it is obvious. The Swede knew. His "handicrafts" were cocaine.

That night, in one of the best hotels in La Paz, a request for a cup of matte de coca (coca leaf tea), invited the question as to whether I wanted a beer later in my room. I declined.

Half an hour after I returned to my room, there was a knock on the door. The waiter from the bar appeared with a bottle of beer and glass on a tray. I said I had not asked for it and he left. Earlier, I had probably inadvertently signaled that I would like a contact to buy cocaine.

These are small incidents in themselves, but demonstrate how all-pervasive the drug traffic has become in Bolivia. In Lima, the incidents can be duplicated. In Bogota, the best spot for buying a small bag of cocaine is on the sidewalk near the Bogota Hilton.

It's when you talk to government officials that the realization hits home: poor countries, such as Bolivia and Peru, are having to invest the time of thousands of people, and millions of dollars, in fighting massive trafficking which is providing, in reality, recreation for affluent North Americans.

It's no secret the United States is pouring tens of millions of dollars into these countries, and helping to train scores of narcotic agents. Why not?

Poverty is obvious wherever one goes, although most of the countries involved in the drug traffic are trying to raise the living standards of the poor.

Now, in the past five years, they have had to divert already scarce resources to combatting a problem coming from the north: a true supply and demand situation. One can argue, of course, that without the problem of drug trafficking, the pace of development would be no quicker. And the issue can't easily be resolved.

But what's frightening is the evidence Dr Nils Noya (**The Journal**, January) has gathered that smoking cocaine paste or inhaling nearly pure cocaine can produce irreversible damage. This should provide a salutary check, and rethink, for those who are calling for easing the law for possessions of small amounts of cocaine.

As long as traffickers can make a fortune by selling highly adulterated cocaine in Canada and the United States, the numbers affected will remain small.

But what would happen if, for whatever reason, cocaine paste or pure cocaine suddenly appeared on North American streets?

While Peru and Bolivia wrestle with cocaine production, Colombia is involved as well in massive cultivation and shipment of another North American and European recreational plaything, marijuana. They don't make a fortune, but the farmers do get more than enough to encourage them to replace coffee bushes with marijuana plants.

As well placed observers point out, action will have to be taken soon to prevent the country from disintegrating into chaos, with drug trafficking playing a major role.

It would be hypercritical for anyone who smokes or drinks to condemn those who smoke marijuana, although there must be reservations about cocaine use.

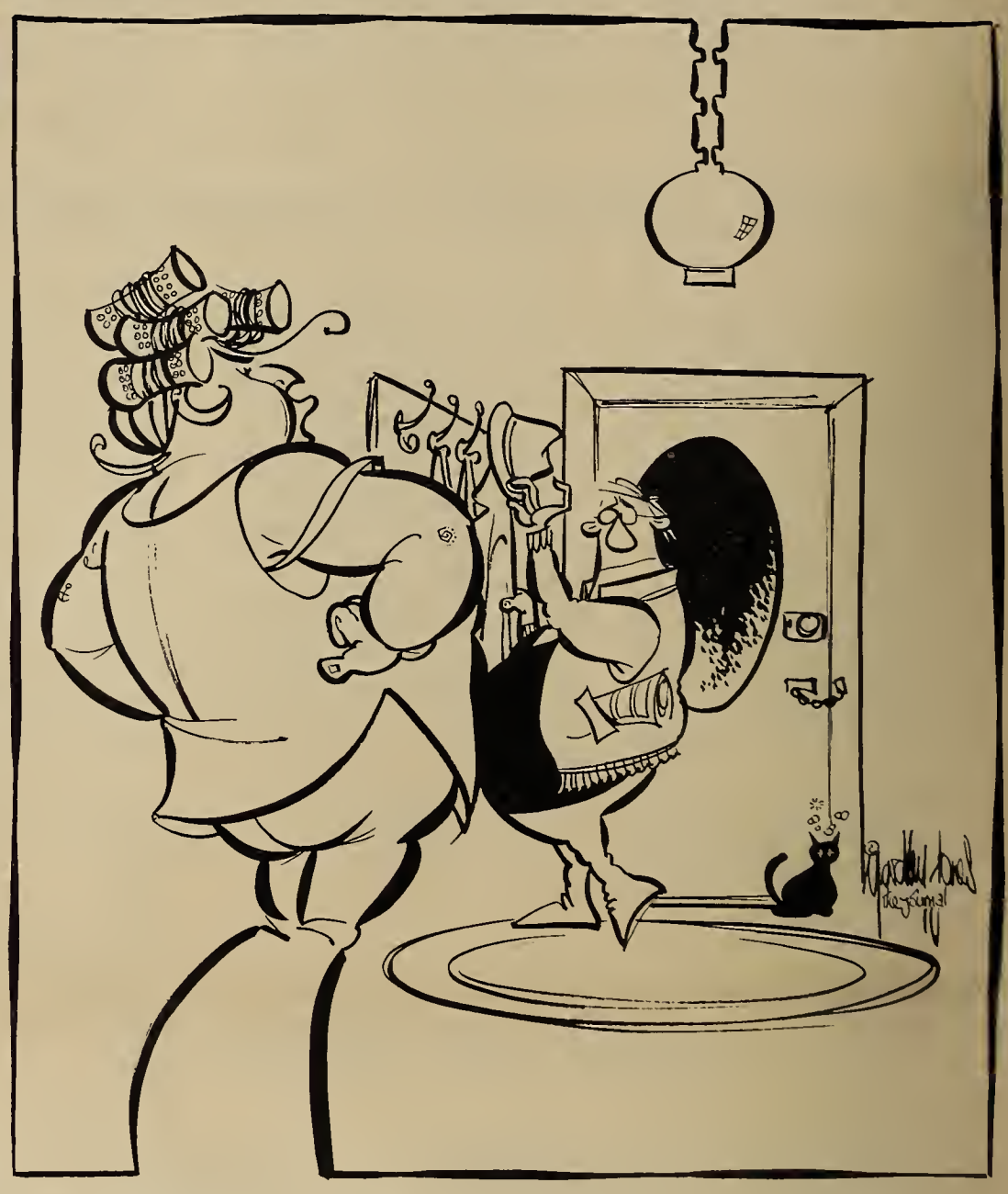
But, the alcohol and tobacco industries are not masterminded by criminals, and are not leading directly to large scale corruption of poor countries. Cocaine and marijuana trafficking from South America are.

It is a fact, and a moral question that must be faced.

The logical answer would be to allow cultivation and distribution of marijuana and cocaine in North America. And who would seriously advocate that?



A street in La Paz, Bolivia, known for cocaine sales



'You're rational! — You been on that low-alcohol beer again?'

Inside Science

Stud

By Stephen Israelstam
Sylvia Lambert
Gus Oki

There have been recent indications in both the popular press and the scientific literature of the use for recreational purposes of the vasodilator drug amyl nitrite.*

However, our observations have led us to the conclusion that a non-pharmaceutical nitrite has become more widely used over the past two years than amyl nitrite, although there is next to no mention of it in the scientific literature. This is butyl nitrite,* commercially used in such products as room odorizers and in jet propellant fuel.

The difference between amyl ($C_5H_{11}NO_2$) and butyl ($C_4H_9NO_2$) is that amyl contains one more methylene group than butyl. In the United States, amyl nitrite is legally available on prescription only. In Ontario, it is found on Schedule D, Part I of the Health Disciplines Act which means it may be purchased from a pharmacist upon signing the Poison Record Book. Butyl nitrite has none of these restrictions.

In the United States, a considerable industry has been established in producing this product which is sold under a variety of names: Locker Room (the most popular brand in Toronto), Rush, LR, Black-Jac, Aroma of Men, Jac-Blaster, Super Bullet, to name a few.

The first three are available in Toronto, and are sold in bars, steam baths, record shops, and 'head' shops (shops which sell paraphernalia for drug-taking, incense, East Indian clothing, beads, and so on) and are advertised and sold as odorizers or incense.

This commercial substitute for amyl nitrite is used more frequently only because it is more readily available.

In Toronto it was found to be the 'drug' of choice, partly because of easy availability but also because many of the users knew it only by its trade name, and had never heard of butyl nitrite as such, or of the drug amyl nitrite. However, those who knew of and had tried amyl nitrite, stated they preferred the effects of that drug.

The common term covering both products is "poppers," a name derived, however, from amyl nitrite which is available pharmaceutically only in fragile glass ampoules which are easily crushed or "popped" to allow it to be inhaled. Almost all of the butyl nitrite products are sold in bottles, although one (Rush) has just begun to appear in ampoule form.

Although the pharmacological effects of butyl nitrite may be similar to those of amyl nitrite, no known studies have been carried out on butyl nitrite which is not a drug as defined by Canada's Food and Drugs Act or the Province of Ontario's Health Disciplines Act. The only physiological information we have is that which applies to nitrites in general. The main effect of nitrites is to dilate the blood vessels and therefore relax the smooth muscles. It is the dilation of the cerebral area that is said to cause the 'high'.

We selected for study the socializing male homosexuals in Toronto, that is, those who attend gay bars, discotheques,

Reports from South America



Harvey McConnell, The Journal's contributing editor (Washington) writes from Peru, Colombia, and Bolivia.
Photos: Harvey McConnell

The Journal



Indian women clear the fields for potato planting on the Andean Altiplano in Peru and Bolivia. Both governments are now discouraging the chewing of coca leaves, another centuries old indigenous crop. The fertile soil is (below) turned easily by the oxen-drawn primitive plow.

Peru fights to dislodge coca plant customs

LIMA, PERU — Profound changes in both the use and the cultivation of the coca plant are being attempted by the Peruvian government.

The short term aims are to control the production of cocaine.

The long term aims are to change a habit of centuries — coca leaf chewing by the Inca population — and to the growing of coca plants anywhere except on government owned and run plantations.

Officials realize some changes cannot come overnight, especially in the chewing of coca leaves by an estimated 50% of the 2.5 million adult Incas who live mainly around Lima and in the high Andes.

The first step was taken in January when a ban was placed on the importation of coca leaves from the mountains to Lima, and the entire Pacific Ocean coastal plain.

"This is the only way we can stop coca leaves coming from the jungle and the mountains to Lima, and being turned into cocaine," Attorney General Nelson Diaz Pomar said.

Ten years ago, it was estimated some 500,000 kilos of coca leaves were imported into Lima and the coastal area. Paradoxically, during the past decade, the number of Incas moving from the mountains to Lima has increased but coca leaf importation has fallen.

Dr Pomar explained: "We found that, over these 10 years, the price of coca leaves kept going higher and higher, and the Indians were spending more money on food, clothing, and housing.

"It is a social and economic problem and it will take a number of years to solve.

"After the government passed land reform acts, the social and economic situation of the Incas started to improve. The numbers who now chew coca leaves has dropped about 50%, and we estimate about 1,250,000 chew daily.

"We believe as the social and economic position of the Incas continues to improve, the number of coca leaf chewers will continue to decline. But it will take time.

"In the future, Indians who live in Lima will have to go to the mountains if they want to chew coca.

"We know they get proteins and vitamins from the coca leaf but if they get good food they will not need coca. Also, in the mountains, they say it gives them energy.

"However, when the Indians come to the coast, many of them forget about coca chewing. In the past, coca chewing usually started between 15 and 18 years of age when people started to work."

Another aim is to change the way of living of the Incas who grow coca plants, and to substitute crops that will earn more money.

"Most of these growers would like to change, but they need credit to do so. We think it will take about five to six years of credit given to them before they can change completely to other crops."

Extending credit to the farmers to change from coca growing is linked to another section of the new act which places coca production firmly in government hands.

Dr Pomar said: "We will have one plantation which will produce coca for production of legal cocaine, and also to supply the Coca Cola company, which each year buys from us 500,000 kilos of coca leaf.

"The sale to Coca Cola is a constant source of dollars, and we have for years exported pure cocaine to many European pharmaceutical companies.

"Our second plantation will be for production of coca leaves for the Incas to chew as, obviously, we shall not be able to stop all of them from continuing the habit."

Penalties for growing coca illegally will now be high: from two to 25 years in jail.

There will be an easing of penalties for possession of small amounts of cocaine. "We consider the consumer is a sick person and there will be no penalty. But anyone found with an amount of cocaine which is more than needed for immediate consumption will face a minimum two years in jail," Dr Pomar added.

Special squads of police will be used in the Andes and the jungle to locate and destroy illegal coca plantations.

Although some opium growing has been reported in the Cajamarca region in Northern Peru, Dr Pomar said the amount is small, and increasing police activity has reduced this even further.

One problem Peru seems not to have is the cultivation of marijuana. "Some is grown in the coastal region but those who use it say it is not very good and that imported from Colombia tastes much better."



Menus in the high Andes feature coca tea



Finely ground coca leaves are sold in tea bag pouches.

CUZCO, PERU — They are packaged individually and look like ordinary tea bags. They are brewed in the same way.

However, the contents are not best Darjeeling but the finely ground leaves of the coca plant. The bags sell for about two cents each in grocery stores in this ancient capital of the Incan empire.

Matte de coca is recommended for the digestion as well as to help the body adjust to altitude in the Andes. To a foreigner, it tastes like a herbal blend from a health food store.

Matte de coca is on the menu in any Andean restaurant or cafe in Peru and Bolivia and is often ordered instead of coffee.

While the tea is drunk by Spanish and Indians alike, coca leaf chewing is confined mainly to Indians.

Calle Santa Cruz in the giant Indian market in La Paz, Bolivia, is the place to find coca leaves.

Women sell the leaves in plastic bags: approximately four ounces cost about 25 cents. The Indians chew the leaves with an ash which acts to release minute amounts of cocaine.

It's an acquired taste. Again, to a stranger, sampling a mouthful of leaves is akin to stripping off and chewing a handful of leaves from a nearby shrub.

Half a lime supplies the acid to release the alkaloid, and there is a slight tingling sensation in the mouth. It obviously takes practice to chew throughout the day.

Compassion alone can cross borders to jailed Canadians

LIMA, PERU — Every week or so, Harold Hickman, vice-consul at the Canadian embassy here, drives to the outskirts of Lima to visit three Canadians held in prison on drug charges.

Officially, he is following his instructions manual from Ottawa on what steps to take when Canadians run afoul of the law while abroad. Unofficially, he applies a human touch, collecting mail, and delivering Canadian newspapers and cigarettes.

Less frequently, he flies to La Paz, Bolivia, where Canada has no embassy and accreditation is handled by Britain, to see the Canadian prisoners there. His visits will probably be more frequent now: six Canadians were arrested in November on charges of possessing five kilos of cocaine.

Mr Hickman said: "We don't look at the guilt or innocence of the prisoners. Our action is to make sure that all is fair."

'There have been enough scare stories about Mexican and South American jails that only somebody really dumb doesn't know the trouble they can get into. . .'

Nor is there any question of the Canadian embassy putting pressure on the host government to release the prisoners. Instructions in the manual are specifically phrased, and the only grounds for protest would be if it was felt the prisoners were being discriminated against because they were Canadians.

There is certainly no feeling that those who get arrested are babes in the woods.

Mr Hickman: "There have been enough scare stories about what goes on in Mexican jails and South American jails that only somebody who is really dumb, or does not pay attention, does not realize how much trouble he can get into.

"People do get arrested, and if they have a fair amount of drugs in their possession, they are going to end up going to jail for quite a while. And it is not a pleasant life."

There is no set routine for informing the embassy when a Canadian is arrested. "Either a friend calls us, or the person in jail gets out a message, or the Lima police call us. In La Paz, we are usually informed by the British.

"If the person arrested does not want the embassy involved, then we do nothing, but that does not happen often.

"We talk to the arresting officer, talk to the prisoners to find out their stories, and we talk to their lawyers or, if they do not have one, give them a list of lawyers who speak English and French.

"We might go and see the equivalent of our crown prosecutor, but that is just to find out what is going on, and what the state of their legal case is.

"Basically, what we do is just show interest and let the government know we are interested in our citizens."

The policy of the department of external affairs is "we don't give financial assistance unless it is a really urgent hardship case, and then it is on a recoverable basis."

In most cases, a message is sent through Ottawa to friends or relatives, for financial assistance. "The friends or relatives send down a few hundred dollars and that enables the prisoner to buy food and get a better bed."

The wheels of justice in Peru and Bolivia, because the legal system is different, grind extremely slowly. Anyone arrested on a drug charge can expect to spend two years in prison at least.

"The equivalent of the fiscal investigates the case, and asks for a sentence. A tribunal holds a hearing, and finally hands down a decision. Quite often, the process is longer than the sentence the fiscal asked for, and when it reaches that point the prisoner is released," he added.

One young man arrested last year in Bolivia was so addicted to inhaling cocaine that his nasal septum bad been destroyed. Bolivian doctors tried unsuccessfully to treat his addiction.

"He was in such bad physical shape that the Bolivians did not want to keep him," Mr Hickman said. "He was sent back to Canada, where of course there was no charge against him."

Mr Hickman never talks about the charges with the prisoner "as they might think you are pumping them for information."

In Lima prison, Canadians and Americans are kept in one cell block and in the minimum security wing. "It is almost a case of reverse discrimination with the Peruvians," he commented.

They can use the money sent from home to buy food from vendors as the regular jail fare is not very nourishing.

In his unofficial role, Mr Hickman takes the prisoners small items and talks "so they don't feel totally disconnected. Sometimes I go out of my way.

"One of the prisoners here is doing handicrafts and has made a wall hanging, which I am trying to sell for him so he can have some money."

From now on, any Canadian or American arrested on drug charges will find the Peruvian laws more severe.

Until recently, many prisoners were allowed provisional liberty outside while their cases were being heard. Those who had been sentenced could try to get a pardon for clemency in the twice yearly releases by the government.

Both of these rights have now been abolished for those arrested on trafficking charges.

However long the legal process may take, Mr Hickman pointed out: "We have to respect every country's system. It may not be the same as ours, but it is their country and their system.

"We expect foreigners to respect ours when they are in Canada, so we have to respect theirs."

Next month: Drinking habits among Yagua Indians and the river people of the Amazon.



Women line up outside Bolivia's main prison in La Paz to visit husbands and friends. Inset: Harold Hickman, vice-consul at the Canadian embassy in Peru.

US, UN, and Peru join force

LIMA, PERU — A mammoth effort to combat illegal cocaine traffic is being made by Peru with help from the United States and the United Nations. The US is training narcotics agents and the UN has supplied six patrol boats for the Amazon River area.

Help is desperately needed, according to Attorney General Nelson Diaz Pomar. "We think there are some 100 or so groups of criminals working in the Amazon jungle area making cocaine paste.

"We know there are a number of illegal air strips for light aircraft to land and take the paste to Colombia for processing into pure cocaine. Most of these criminal bands have been organized by people from the United States and Colombia."

A number of Peruvian policemen have been wounded in running gun fights with traffickers. In Lima, the situation took a grim turn in November when an undercover narcotics agent was kidnapped, tortured, and killed.

The trafficking is also directly affecting Lima schoolchildren. Many of the Colombian traffickers are using a barter system — marijuana for cocaine paste. Over the past two years, there has been an upsurge of marijuana use in school and colleges.

Many of the young people are starting to mix marijuana with the crude cocaine paste to form "*mixto*".

"So far *mixto* smoking has been confined to Lima although we don't have any statistics yet about how many young people use it," Dr Pomar said.

"But we do know doctors are seeing more and more patients who use the drugs, and the government is making a special effort to educate the students about this truly dangerous mixture."

Dr Pomar said: "It is estimated some 60% of the illegal cocaine produced comes from Peru. It is most important to us that we stop the trafficking."

For the past two or three years, selected Peruvian policemen have been sent to the United States for special training. However, at the request of the Peruvian government, the US Drug Enforcement Administration sent down special agents to train 33 men from the Guardia Civilia, the plain clothes Peruvian Investigative Police (PIP), and the customs service.

All of the men had been specially selected for the training, and most were former paratroopers in the Peruvian Army.

At a recent official ceremony in a private club in the Lima suburb of San Isidro, the narcotics agents were presented certificates of training by American DEA officials.

Dr Pomar emphasized this special school was a major step forward. "For the first time, we have now trained men from all branches of the police and customs service so we can make a



Special US Drug Enforcement Administration training agent John Means (centre) with General Samuel Yepez Puyareda (left) and his staff.

Bolivia's drug fight: penalties plus education

LA PAZ, BOLIVA — It was a David and Goliath situation a year or so ago: David being the Bolivian government trying to battle the Goliath of cocaine producers and traffickers.

Now, with massive aid from the United Nations and the United States, Bolivia, one of the poorest nations in the world, has at least a sling, and a chance to fight on something approaching equal terms.

This is the feeling of Colonel Ovidio Aparicio, director of the entire Bolivian fight against drugs.

His office not only seeks out illegal traffic and production, it is also responsible for trying to curb drug abuse within Bolivia (**The Journal**, January), and devise long range plans to end coca plant cultivation, and coca leaf chewing by a large number of the Inca population.

'We would at least like to fight traffickers on equal terms. . .'

In addition, Colonel Aparicio is responsible for rooting out corruption — he has already forced two judges to resign and a third has been jailed — and dealing with foreigners, mainly from Canada and the United States, who try to smuggle out pure cocaine by the kilo.

Colonel Aparicio pointed out: "The major traffickers have planes, a very good communications system, and a lot of money. We would, at least, like to fight them on equal terms."

Much of the aid received from the UN and the US is quite basic: communications equipment such as radios and teletype machines; cameras; tape recorders; and field equipment, such as tents.

Already, requests have been put in for more aid in 1978 and projections are being made for what might be needed in 1979.

Major items being sought are helicopters and light planes which can seek out illegal coca plantations.

It has meant a lot of action and work in the two years since the office was established by Colonel Aparicio (who, rumor has it, will soon become commanding general of all three branches of the national police).

In 1973, as then-director of the Guardia Civilia, he attended an international conference of police chiefs in San Antonio, Texas, and learned at first hand, the problems the US was facing with drug trafficking and addiction.

Soon after, Bolivia started to develop a drug problem among its young people and, in 1975, Colonel Aparicio established the national narcotics bureau.

In a modest office at his headquarters in a house in surburban La Paz, Colonel Aparicio discussed the present situation and what he hopes to achieve eventually.

Much of the effort against traffickers is in the western and eastern parts of the country, the centres of coca leaf production, and in the illegal laboratories where cocaine powder is refined for sale abroad.

One area that has received special attention is the town of Santa Cruz, the hub of much of the illegal production. "We have increased greatly the number of police personnel in the area and this has allowed us to discover a number of cocaine producing factories," the colonel added.



Ovidio Aparicio

A number of Bolivian policemen have been sent to Washington for special training. And, as in Peru, the US Drug Enforcement Administration has helped in the training of narcotics agents here.

One of the most important moves Colonel Aparicio has made is to strengthen cooperation with police forces in neighboring Brazil, Peru, Paraguay, Argentina, and Chile. The results have been dramatic.

The colonel explained: "Just recently, for example, our cooperation with the Brazilian police enabled us to discover two major trafficking rings in the jungle area on our borders. We arrested 54 people, and confiscated five kilos of pure cocaine, 2,000 kilos of marijuana, 50 kilos of dynamite, and 68 rifles and pistols.

"These arrests came because of our liaison with Brazil and because we have now put specially trained policemen along the borders."

In La Paz, the capital, where pure cocaine can be bought for around $3,000 a kilo, the number of policemen detailed to the narcotics division has risen from 19 to 240 over the past two years. An undercover intelligence service has been set up and operates in schools, night clubs, and amusement centres.

This is coupled with an intense government education program to warn people of the dangers of inhaling pure cocaine, or smoking the mixture of cocaine paste and tobacco.

Colonel Aparicio has been instrumental in advising the department of justice on ways to ease the penalities for personal possession of small amounts of cocaine.

"We are making law more suitable to the realities of the situation," he said. "If it is established that the quantity a person has is for his own use, and not for trafficking, then the offence will be considered a simple one."

'The most recent coup involved five Canadians arrested within a two-week period . . .'

But for traffickers, and this includes foreigners who try and smuggle out cocaine, penalties will be severe.

Colonel Aparicio said in the past year 48 North Americans, 35 Colombians, 14 Chileans, nine Argentinians, and four Peruvians have been arrested for trafficking.

The most recent coup was six Canadians arrested within a two-week period. They were caught with a total of of five kilos of pure cocaine in their possession. (At current street prices of $2,000 an ounce, and presuming the cocaine was cut to 25% purity, the five kilos would be worth $714,000 in the US or Canada.)

Colonel Aparicio believes that no one can come to Bolivia and not know how strict Bolivian law is concerning drug trafficking.

"We work closely, for example, with the Canadian and American police, and we often know when traffickers are heading towards Bolivia. We have good cooperation within Interpol in Europe, especially with the police in Britain.

"A majority of the people we arrest are traffickers. They are experienced and they know, for certain, the law here.

"Unfortunately, there have been people who have given information to the press claiming their son or daughter has been arrested here in Bolivia just for using a small quantity of drugs. This has created a false image.

"Maybe this has been good for us because committees have come from the United States to see and talk personally to those we have arrested, and discovered that many were traffickers and they had broken Bolivian law."

Two programs are now being carried out to get at the root of the cocaine problem — the growing of the coca plant.

Colonel Aparicio explained: "We are now carrying out a census of all farm workers so we will have a register which will show the volume of coca leaf production, the areas where it is cultivated, and the number of families dependent on coca leaf production for their income.

'I must be crazy to keep this job. I have to fight the government, the ministeries, and the families of traffickers. . .'

"We are also looking at the health and education problems of the farm workers, as well as the agricultural problems.

"For example, we would like the farmers to be able to grow fruit (at present, growers are plagued by the Mediterranean fruit fly) that can be shipped to market not only in Bolivia but abroad as well. In this way, we hope to provide them with more income than they would get from coca growing."

Within 10 years, the government hopes to reduce production of coca to a minimum, as well as the chewing of coca by the Incas, a custom of centuries.

"We want to educate the Indians about coca leaf chewing. It has been found that the young generation of Indians seldom chews coca leaves. As the nutritional needs of the Indians are met, this reduces the need for coca chewing.

"We have started studies to see how we can change this habit among the Indians who still chew, especially the workers in the mines."

Within the government, the colonel has a tough reputation, and his fight against official corruption is fierce. He has sent both judges and policemen to jail.

Colonel Aparicio, with a smile, added: "I must be crazy to keep this job. I have to fight with the government to avoid interference, I have to fight with all the ministries, and I have to fight, as well, the families of the more than 500 traffickers I have sent to jail."

But he is pleased that UN and US observers who have come to Bolivia return home impressed with the efforts being made against trafficking.

Colonel Aparicio summed up: "Drug trafficking is an international problem. Bolivia cannot fight it alone.

"We see it as a long term problem with no quick solution. It is a problem of demand. As the international market for cocaine increases, demand increases, and, naturally, more pressure is put on Bolivia.

"But I believe the efforts we have made could be found useful for other areas of the world."

against illegal cocaine traffic

major attack on the illegal trafficking."

Dr Pomar has also requested that the US help to train Peruvian magistrates in how to deal with traffickers who come before them (**The Journal**, January).

The amount of money involved in cocaine trafficking is enormous.

A Lima undercover agent, who arrested a trafficker recently, was offered, on the spot, $130,000 in cash if he turned his back. In another raid, three narcotics agents found four traffickers with $500,000 cash in their possession. The policemen put the money into the Bank of the Nation.

Dr Pomar said: "Our policemen have a high morale and I do not think bribery is a big problem. People outside our country must realize that trying to stem the cocaine trafficking is a point of honor.

"Most Peruvians do not want to have their country gain the reputation as a major drug producing nation. For this reason, we do not worry very much that our specially trained narcotics agents will, or can, be bribed."

General Samuel Yepez Puyareda, a member of the Guardia Civilia for the past 33 years, is in charge of the narcotics section, and has no illusions about his job.

"There is going to be a problem as long as North Americans are willing to purchase drugs with their hard currency.

"The drug problem is an all pervasive problem throughout the world, and it requires on the part of government officials everywhere, a very determined effort to put up an effective fight against it.

"I think in Peru we can now take a well-coordinated action against the drug traffic, and the results will be very good. My aim is to try and curb as much production of cocaine as possible."

General Puyareda's major points of reference are the semi-tropical town of Tingo Maria, where cocaine powder can be purchased, and the Amazon, where cocaine paste is produced.

The United Nations Fund for Drug Abuse Control, after a study of the situation in Peru, has purchased six American made patrol boats for use on the Amazon.

Cocaine paste is either flown out from illegal airfields or shipped down the Amazon by boat to the Colombian border port of Leticia.

Most of the boats carrying cocaine paste make their run of several hundred miles in darkness. The Amazon is dangerous enough during the day for small craft — huge floating trees are a constant hazard — but at night can be even more lethal.

The patrol boats provided by the UN will be utilized by customs agents and police trained specially to function in the vast rain forest.



The Guardia Civilia receive certificates of training from US Drug Enforcement Administration officials in Lima suburb of San Isidro.

US-bound illicit drugs channelled via Canada

BOGOTA, COLOMBIA — A large amount of cocaine that reaches the eastern United States from Colombia is first smuggled into Canada and then moved across the border, officials here believe.

Every trick, including false-bottomed suitcases, and hollowed out linings of leather bags, is used by traffickers who fly to Montreal and Toronto on commercial flights.

It is believed about 25% of the illegal cocaine shipments are moved across the Mexican border, after being flown out of Colombia in light aircraft, destined for the Canadian and American west coasts.

Marijuana, on the other hand, is shipped out by the ton on Colombian-registered freighters. Near the east coasts of Canada and the United States, it is offloaded into small ships and run ashore, in much the same way as liquor was moved in prohibition days.

Although the freighters may sometimes look like tramp steamers, they are equipped with highly-tuned electronic gear trying to detect US Coastguard ships which may be in the vicinity.

Despite increasing activity by Canadian and American officials, it is estimated some eight to 10 million tons of marijuana were smuggled into North America last year from Colombia.



In La Paz, between 75% and 80% of all traffic accidents involve drunk drivers. Most of them drink beer because it is cheap.

A legacy of the Spanish conquest

Alcoholism rampant among silver mines

LA PAZ, BOLIVIA — It has been the same for nearly 400 years. Every weekend, the thousands of Indian workers in the silver and tin mines of Bolivia get dead drunk: the women stay sober to tend them.

"By any international definition, these men would be considered alcoholics. But when you consider it has been such a part of their culture for centuries, then it is hard to say whether they really are or not," suggests Gregorio Aramayo, a psychiatrist with Bolivia's National Institute of Drug Dependence.

The drinking patterns of the mine workers is one part of a mosaic of alcohol abuse found in Bolivia.

In the capital of La Paz, a recent study by the government traffic control office showed that between 75% and 80% of all traffic accidents involve drunk drivers. A survey of 7,000 high school students "showed some 5% would be classed as alcoholic," Dr Aramayo added.

In the rural areas, the favorite drink of the Incas is *chicha*. It is made from corn which is first chewed, put into the sun, and finally boiled and allowed to ferment.

Dr Aramayo, who has worked there for some time, explained that the main drink in mining areas is *pisco*, a grape brandy. "The men start drinking on Friday night, mixing *pisco* with fruit juice.

"By Saturday, they are so drunk they don't care, and just drink from the bottle. The women hardly drink at all as they have to take care of their drunk husbands and sons."

The drinking pattern of the mines is a legacy from the Spanish conquest. Under the Incas, the Indians worked in the mines for nine months every seven years, and spent the rest of their time farming.

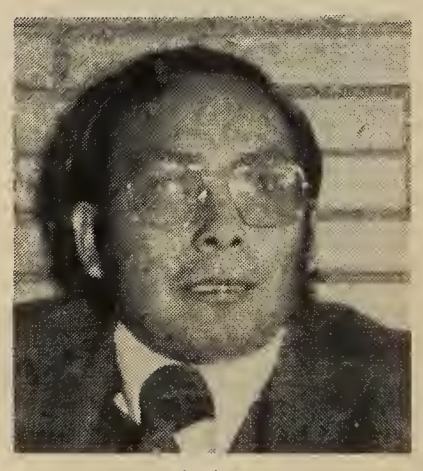
From the 16th to the 18th century, the Indians were forced to work in inhuman conditions. Until the mines were nationalized in 1952, conditions had been little better under private owners.

Land reform, also instituted after the 1952 revolution, meant most of the farm land was divided among the Indians, and this is reflected in drinking patterns.

Dr Aramayo explained: "Although the farmer drinks *chicha* on the weekends, he knows he is working for himself. But the miner still feels he is working for somebody else.

"On Mondays, there are great lines of miners waiting to see the doctors. Absenteeism is great, and even among the men who go to work, the accident rate is high."

Unfortunately, the pattern of going into the mines, and weekend drunks, cannot be broken. The mines are located in isolated areas and there are no nearby industries to offer other employment.



Gregorio Aramayo

"The only thing a father wants is for his son to become old enough to earn money to help out, and the only place the son can get money is working in the mines," Dr Aramayo said.

Until the formation of the institute several years ago, there had been no organization in Bolivia to tackle the problems of alcohol abuse and prevention. Dr Aramayo said it is hoped a plan can be produced that will reduce the problem of drinking among the miners.

Paradoxically, it has been American-led evangelists, who, preaching abstinence, are making a major impact in changing the drinking pattern of the farm workers.

However, among the thousands of very poor who do not own land, the problem is much more acute.

Dr Aramayo: "It is a very serious problem, especially among children, as they are not well fed and *chicha* replaces food. We have found that if they come to the city and get a job, and the family can eat well, then the quantity of *chicha* they drink, falls off."

The main drink in La Paz is beer. Most drunk drivers arrested have been drinking the cheap beverage.

The only help the problem drinker might receive is in the general hospitals. "But they only go in for a few days for a short treatment, and nothing is programmed," Dr Aramayo said.

Although many high school teenagers drink, the major problem among the poor Indian youth of La Paz is solvent sniffing.

"We are now trying to find out the extent of the problem, but I would say an alarming percentage of the Indian youth sniff paint thinner and glue. We have started an education program to warn children of the dangers of sniffing."

Marijuana use has become widespread among school children in the past five years. Because cocaine is expensive, its use is confined to private schools where the students have enough money to buy it.

The most widely used hallucinogen is available some 30 minutes away by car from La Paz in the area called the Valley of the Moon. It is the San Pedro cactus, which grows wild.

Dr Aramayo observed: "The cactus is there in the thousands. Usually bits are cut off and boiled and the liquid is drunk. The effect is similar to mescaline's.

Dr Aramayo concluded: "We have many problems here and we have opened this institute with the objective of trying to control drug and alcohol problems, and to help the people who suffer from them. We hope later to open centres in other parts of the country."

Crude rum is tax hike target

LIMA, PERU — A thumping 50% tax increase on alcohol is being coupled with a large scale education program by the Peruvian government in a bid to stem the rising problem of alcoholism.

It is estimated there are some 300,000 alcoholics among Peru's 16 million population. The majority are found in the slum areas around the major cities, especially Lima.

The tax bite is aimed principally at the crude rum which has been selling at 40 soles (about 35 cents) a bottle, in almost any store.

The dangers of drinking are being tackled in a variety of education programs, including seminars in schools, special training for lecturers, and talks to industrial and agricultural workers.

Priests from the Roman Catholic Church have also joined in the campaign, and give advice and help to their parishioners.

Government officials admit little has been done in the past to tackle the alcohol problem in Peru. A special danger is that many alcoholics make their living by driving taxis, trucks, and buses. Now the laws on drunk driving have been tightened up and a fourth offence means a driver loses his licence for life.

Meanwhile, a severe bout of inflation over the past few years, has caused a change in the drinking habits of the well-to-do. Scotch, which used to be the prestige drink to serve guests, is retailing for some $20 a bottle. Now, hosts serve the local grape brandy, *pisco* in a sour mixture practice which, at one time, would have been seen as gauche, to say the least.

"Scotch" and "gin," Peruvian style, are on sale at reasonable prices, but the taste is more akin to rum's than to anything.

For variety, people living in mountain areas mix coca leaves with crude alcohol.

Cocaine: vogue import

LA PAZ, BOLIVIA — It was not until some five years ago that the abuse of drugs was even considered by doctors and officials in Bolivia. Now it has exploded with a vengeance.

"We were simply not prepared. None of us had really studied anything about drugs" said Nils Noya, director of Bolivia's National Institute of Drug Dependence.

In the ensuing five years, Dr Noya has founded the institute and become one of the world's experts on cocaine addiction, and the severe problems now being seen in those smoking cocaine paste or inhaling pure cocaine (**The Journal**, January).

Dr. Noya, who trained in Bolivia and Mexico as a child psychiatrist, became involved "when I started seeing young people suffering from the effects of LSD. A majority would be called middle-class kids.

"Then, university and high school students started to smoke marijuana, which is very common here now."

Oddly enough, it was not the North American influence which prompted the widespread use of cocaine. It goes back 50 years to Paris.

Dr Noya explained: "The most important influences in Bolivia have been European, especially the French, Belgian, and German cultures. The whole structure of our military, for example, was on German lines until the revolution of 1952 which overthrew the three-family oligarchy which ran Bolivia.

"French thought is especially important among the intelligentsia, and most of our writers have lived for a time in Paris or Brussels."

Following the formation of a military government here in 1971, Dr Noya observed a mood of depression among many people in the arts.

"Then, for whatever reason, people started remembering France in the 1920s when cocaine was the vogue. You could get cocaine wine, cocaine cigarettes, even cocaine champagne.

"This use of cocaine has been brought to life here 50 years later.

"Until then, one simply did not hear about cocaine addiction in Bolivia. Obviously, there were some people who inhaled cocaine on the odd occasion, but in no way like it is today."

Dr Noya added: "Maybe the first one we should blame is Freud. After all, he wrote a nice paper about cocaine, explaining what a wonderful drug it was."

Women accept Bolivian macho

LA PAZ, BOLIVIA — Friday night is drinking night in this city, but *machismo* rules: the men must drink, but the women mustn't.

"The custom is that on Friday night every man will go out drinking, and we women accept that," explained Maria Bostos, a clinical psychiatrist at Bolivia's National Institute of Drug Dependence.

And the pattern has definite social and personal connotations.

Ms Bostos said: "If the man, whether he is married or single, does not go out to drink on Friday night, he is considered a homosexual. And if a woman goes out on Friday night it is certainly not to drink, or she is looked upon as easy."

The custom applies to women whether they are married, or, like Ms Bostos, single. "The men drink and play poker. It is a very *machismo* thing. And, I am afraid to say, the women accept this situation, which is why the men do it."

The double standard view of men and women drunks is still extreme in Bolivia. Ms Bostos said: "The man is pressured to drink more and the women always to be moderate."

Ms Bostos, who was formerly a teacher, has observed increased drinking among teenage girls, who are under a dual pressure.

"Although it is not talked about in public, sexual patterns are changing even in Bolivia, and there is much greater pressure than 10 years ago for teenage girls to make love with their boyfriends.

"But, the young women still have to live a passive role. They must stay at home until they marry, and then must be in at certain hours, while the young men can stay out as late as they want, and get as drunk as they want, and it does not matter.

"It is this conflict of roles which is leading to much more drinking among young women."

As pregnancy is still considered a catastrophe for an unmarried woman in Bolivia, use of the contraceptive pill, which can be bought without prescription, is widespread. Almost never is it prescribed by a doctor.

Ms Bostos pointed out: "La Paz, for the middle class woman, is still a small city. An unmarried woman will simply not go to a doctor for the pill because she is afraid a friend, or member of her family, would find out. Obviously there are a lot of young women who are taking the pill, who, for medical reasons, should not. But they don't know it."



Maria Bostos

'The custom is that men drink on Friday night, and the women accept that. . . '

Editor... Letters to the Editor... Letters to the Editor...

Criticisms of AA methods are challenged

I would like to make some comments on a letter written in **The Journal** by Patricia Armstrong of Vancouver, BC. Either this person does not fall in the category of alcoholic, or she is indulging in a bit of falsehood as a copout from AA.

I would like to answer this letter according to the points listed in her letter. For instance, number one is asinine in that if it were so, she must have gone to AA before she took her first drink. Also, show me an alcoholic who has not had a preoccupation about booze.

Number two: it is not "the exact same people" as she indicated. If it were so, how could a 42-year program go from two to one million in the world? (sic)

Number three: she says she learned the 12 steps. I wonder if she ever applied any of them to herself and realized that the total scene is an infinite learning process?

Number four: no one is encouraged to go it alone because the problem is too big for one person. Unity is the name of the game.

Years ago, I made the statement that a confirmed alcoholic, in process of a recovery, should not make a major decision that could affect his life for all time unless he or she had at minimum two years of total abstinence. After reading this letter of Patricia Armstrong's I feel the minimum should be raised rather than lowered.

Even if all of Ms Armstrong's observations are, for her, correct at this time, she should be very careful where she expounds these theories as she could endanger another person's sobriety.

The double talk in the last paragraph is morbidly amusing. It reads thus: "I am not running down AA, I only feel the program is not as good as it should be."

I have only this to say to Ms Armstrong. I would like her to take 10 people that feel the same as she does, and I will take 10 of the type she refers to in item two. At the end of 10 years, I will still have 10 sober alcoholics, and I am willing to wager anything that she won't. And as a last jibe — get a little time in, fools walk in where angels fear to tread.

Ernest M. Mitchell
Antigonish, Nova Scotia

AA's only the first step

(Reprinted from The Journal, November, 1977)

I want to say that I believe it's possible to leave Alcoholics Anonymous, venture out quite alone in the world, and have a very meaningful life.

I was an alcoholic for several years. I became very ill — thankfully — and this gave me time to dry out. Incredibly, my brain which had just been vegetating, began to function again. It is this, more than anything else, that has kept me from drinking again (2½ years).

I attended many AA meetings but began to notice that:

1) it was only at these meetings I even thought of liquor;

2) the exact same people continue to attend these meetings — not just for a few months: it becomes their way of life. Certainly better than drinking;

3) once I learned the 12 steps — really learned them — I wanted to branch out. I wanted to go forward, do things on my own, learn new crafts, etc.

4) I believe AA is a vital first step but should only be a stepping stone. I found none of this. No one is encouraged to go it alone. These people live only for their meetings — make friends only with other alcoholics.

I feel this is a dreadful state for it would appear these people have substituted alcohol for another type of addiction — the continual meeting. They are, in fact, afraid to face the world and its responsibilities.

I am not running down AA for certainly it has done more good than any doctor or psychiatrist. I only feel the program is not carried out as successfully as it could be.

I know most people disagree with me but there are many of us who feel this way.
Patricia Armstrong
Vancouver, BC

'One can live a useful life' in AA

Patricia Armstrong's letter in **The Journal** is of interest because it makes clear the fact she is not on the Alcoholics Anonymous program. As a recovering alcoholic, I found myself thinking like Patricia and had it not been for advice from my sponser, I too might have written an analogous letter.
letter.

Patricia should learn the 12 Traditions and try to live by the 12 Steps. We do not "learn" the 12 Steps, we practise them daily when we are on the program.

No man or woman living the AA program is afraid to face the world and its responsibilities as Patricia believes. I and hundreds of thousands of recovering alcoholics in many countries, including Canada, lead useful lives outside the rooms of AA.

The Rev Ronald Forbes
All Faiths' World Alcohol Projects
London NW6, England

Saved by these 'exact same people'

I am writing in regard to the letter to the editor, AA's only the first step.

First of all, I would like to say that I cannot speak for "many of us," I can only speak for myself.

I thank God that those so-called "exact same people" were at the AA meetings when I reached out for help for my alcoholism 20 months ago. I feel they care and understand the alcoholic. I have a belief in God today and I believe AA is a God given program. I pray that those "exact same people" continue to attend AA meetings so when the next alcoholic reaches out for help, they find it. I also pray that God sees to it that I can be there with them and not just to "learn" the Twelve Steps of AA, but to practise their principles in all my affairs.

Terry S
Campbellford, Ont

The Journal welcomes Letters to the Editor. Letters bearing the full name and address of sender may be sent to: The Journal, 33 Russell Street, Toronto, Ontario, Canada, M5S 2S1.

Stimulates group talk

As a federal parole officer working directly with narcotic offenders, I find **The Journal** has proven to be most helpful.

Many of the articles stimulate group discussions for my weekly group meeting. Good luck.

Mr R Blumenberg
Chicago, Illinois

Thanks

I would like to extend our thanks to **The Journal** for its comprehensive and up-to-date reporting on drug-related matters. We look forward to receiving future issues of **The Journal**.

Robert C. Fahlman
Research Analyst
"HQ" Drug Enforcement Branch
Royal Canadian Mounted Police
Ottawa

finds sex is the key to butyl nitrite 'craze'

steam baths, since butyl nitrite is rtised widely in most homosexual azines and because observation ated use among this group is very alent. During the months of October November, 1977, more than 100 le were interviewed in bars, disques, and steam baths.

l those interviewed were male osexuals whose ages ranged from 19 years. They appeared to come from middle socio-economic groups and a fairly wide variety of occuns: clerks, salesman, businessmen, hers, students, librarians, and rs.

e man reported having used amyl te in San Francisco as early as 1963. ever, most reported having tried nitrite for the first time during the year, so the craze in Toronto ars to be of very recent origin.

tyl nitrite is taken most frequently ght and is associated with such ities as dancing, listening to music, sex. The effect of one sniff is ted to last about one minute and subjects sniff it no more than three over a short period (that is, on one sion') but some take it on as many 'occasions' during an evening.

e main physiological effect reported sers of butyl nitrite is increased t beat. Flushing of the face and and a throbbing in the head are common. Physiological effects, are considered mildly unpleasant, eadache and occasionally nausea veakness.

e pleasant effects which motivate e to use butyl nitrite are sometimes described as lightheadedness, a pleasant dizziness, or change in reality. Feelings of warmth, happiness, wildness, and calmness are reported. However the most frequent and important reason given for using butyl nitrite is the effect it has on sexual activities.

'The butyl nitrite 'craze' is a recent phenomenon, and appears to be concentrated among male homosexuals . . .'

Specific reports of the uses or effects of butyl nitrite during sex are: preventing premature ejaculation, improving orgasm, general relaxation, and making the whole experience more exciting. It is also claimed by some to make the sexual partner seem softer, more human, kind, or sexy. On the other hand, some say it makes the characteristics of the other person less important. A minority report they cannot enjoy sex if they use butyl nitrite during it.

Since most of the interviewees take butyl nitrite in conjunction with alcohol and/or marijuana, the reported effects may be complicated by the effects of these other drugs.

Some subjects who may take it on several occasions during an evening report that the effect changes with use; others say the feeling or effect is the same but is of shorter duration each time; while still others claim there is no difference at all between the first and the last time.

In summary, the butyl nitrite "craze" is a recent phenomenon in Toronto and so far appears to be concentrated among socializing male homosexuals, although this does not preclude the possibility of its occasional use among male heterosexuals and females.

Although some of the physiological effects of amyl nitrite (which in the past was taken to relieve angina pectoris) are known, there have been no studies on the effects of inhaling butyl nitrite.

There are definite, if not pressing, areas of research interest: what are the toxic effects, if any, or butyl nitrite? Might long-term usage produce dependence? Do alcohol and marijuana have additive or synergistic effects when taken in conjunction with butyl nitrite? To what extent may the pleasant effects be attributed to physiological factors and to what extent to psychological factors?

When these questions are answered we can then look at the issue of whether there should be controls governing the sale and use of butyl nitrite. If the effects should prove to be non-toxic, then butyl nitrite might be examined in regard to its potential usefulness.

***Generically the terms are isoamyl and isobutyl nitrite but they are usually referred to as amyl and butyl nitrite.**

(Mr Israelstam and Ms Lambert are senior research assistants with the Addiction Research Foundation of Ontario. Mr Oki is a scientist with ARF).

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Heart group attacks lack of smoking information

MIAMI BEACH — The executive committee of the American Heart Association has approved a report which blames cigarette smoking for 37% more early heart attack deaths, and 19% more premature deaths from lung cancer.

In a strongly-worded report released at the association's annual meeting here, the claim is made: "Cigarette smoking is responsible for 325,000 premature deaths each year, and total mortality is twice as high in cigarette smoking as among non-smokers."

The causes of such unneeded deaths is now more clearly understood, the report notes.

"Nicotine and carbon monoxide have been further incriminated as the chief harmful ingredients. Not one of the harmful ingredients are (sic) entirely removed by filters presently available, particularly carbon monoxide, although there has been a considerable reduction in tar and nicotine. While efforts at further reductions should be encouraged, the development of a 'safe' cigarette with respect to all the associated diseases seems unlikely."

Cigarette smoking is particularly bad, the report states, in people who have other risk factors, such as high blood pressure, diabetes, or a high amount of cholesterol in their blood. "Such high risk persons who smoke place themselves in serious joepardy."

In addition to heart attack and cancer risks, the report adds: "Smoking is also the principal cause of chronic bronchitis and emphysema, which in turn are the chief causes of pulmonary heart disease, and which aggravate other types of heart disease."

While encouraged by a drop in smoking by middle-aged adults, and in professional groups, the report expresses alarm at the number of young people taking up the habit, particularly teenage girls.

"Physicians, nurses, and other health professional have an obligation to inform patients routinely of the hazards of smoking, and to provide assistance to them in their efforts to quit the habit," the report says. "They should set a personal example by not smoking cigarettes themselves, or allowing it on their premises."

In addition, these professionals should explain that stopping smoking has beneficial health effects, and "research findings on the benefits of cessation from smoking, from epidemiologic, clinical, and pathological studies, should be brought to the attention of the consuming public more forcefully and persuasively."

The report also urges a ban on "seductive, misleading advertising which might induce children and young adults to take up smoking." It says adults who smoke should not do so in the presence of children, and that the sale of cigarettes where children can get hold of them should be banned.

Sale of tobacco to minors should be a legal offence in the same way that sale of alcohol is, the report says. The American government, it adds, should "refrain from granting subsidies to promote the growth, manufacture, and sale of tobacco."

The report was approved by the executive committee of the AHA following its submission by an ad hoc committee on cigarette smoking and cardiovascular disease which was chaired by Dr William B. Kannel, director of the Framingham Heart Study. Other committee members were Drs Joseph T. Doyle, Donald T. Fredrickson, and William R. Harlan, Jr.

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Around the World

Black research

A leading black churchman has urged the need for substantial objective research into the question of alcoholism among the New Commonwealth ethnic community now living in Britain. Rev Moshe Sephula, presiding elder of the African Methodist Episcopal church in Britain, believes the time has come for "real academic research into this problem. It's dimensions are unknown. We really have no clear idea of whether we have a serious problem or not. In many black churches there is total abstinence. Among the non-church-going black community there is a considerable amount of drinking — but the extent of alcoholism as such is simply unknown," he said.

Against smokes

The number of teachers in England who smoke has fallen from 46% to 28%, according to a recent survey. Eighty-nine per cent of secondary school teachers and 66% of primary teachers want to play an active part in educating children and young people not to smoke. The Teachers' Advisory Council on Alcohol and Drug Education, and Action on Smoking and Health, have published jointly 22 fact sheets on smoking to help them in their task.

Side effects

Britain's Committee on the Safety of Medicine claims not enough doctors are reporting to it on adverse drug reactions in patients. A working party has been set up to find ways to improve the reporting mechanism. The committee also says more detailed advice on drug side effects should be given to the doctor.

amphetamines

factsheet

Amphetamine and its related drugs are central nervous stimulants, with actions resembling those of the naturally occurring hormone, adrenaline. The best-known members of this group are amphetamine itself (eg Benzedrine), dextro-amphetamine (eg Dexedrine), methamphetamine (eg Methedrine), phenmetrazine (eg Preludin), and methylphenidate (eg Ritalin). Cocaine, though chemically not related to amphetamine, has actions so closely similar that it should also be included among the stimulants, even though it is legally classed as a narcotic.

In the past, amphetamines were widely used medically to treat depression, obesity, and a variety of other conditions. At present, their use in Canadian medicine is limited to a few rather uncommon conditions including narcolepsy (uncontrolled fits of sleep), minimal brain dysfunction, and certain kinds of over-activity in children. Other drugs with very similar structures and effects, but which are claimed by their manufacturers to be different from amphetamines, still have somewhat wider medical use.

People also use amphetamines for non-medical purposes: to avoid sleep while studying or driving; to attempt to improve athletic performance; to counter the effects of depressant drugs.

Under the slang name 'speed,' amphetamines, particularly methamphetamine, have been widely used specifically for their mood-altering effects. Chronic high dose use of amphetamines by injection has been a serious social, medical, and legal problem in several countries.

Amphetamines may be taken by mouth, sniffed, or injected into the veins. It usually appears as yellowish crystals and may be mixed with other materials such as non-drug fillers. Cocaine is most commonly sniffed, but it can also be injected under the skin or into a vein.

EFFECTS

The effects of amphetamines and cocaine, like those of adrenaline, are exerted not only on the brain but also on the heart, lungs, and many other organs.

Short term effects, those produced by a single dose, appear rapidly after the drug is taken and disappear within a few hours. The speed and intensity of effects are greatest when the drug is injected into a vein, and lowest when it is taken by mouth. The type and duration of effects also depend greatly on the amount of drug taken.

At the low doses usually prescribed medically, the *physical effects* include reduction of appetite, increased breathing and heart rate, raised blood pressure, and dilation of the pupils. If larger doses are taken, dry mouth, fever, sweating, headache, blurred vision, and dizziness may occur. Very high doses may cause flushing, pallor, very rapid or irregular heart beat, tremor, loss of coordination, and collapse. Although few deaths have been reported as a direct effect of amphetamines, some have occurred as a result of burst blood vessels in the brain, heart failure, or very high fever. Death from cocaine overdose is usually due to convulsions or arrest of breathing.

Short term psychological effects include increased alertness and postponement of fatigue, and a feeling of well-being ('euphoria') and mood. With increasing dose, the user may be talkative, restless, and and may feel a sense of power and superiority. He may begin to do things over and over, without apparent reason. Many users become agressive and hostile.

Long term effects caused by repeated use of amphetamines are of two types. Some are simply exaggeration of the short term effects, while others are quite different and occur only with prolonged use. Effects may be direct or indirect. *Direct* effects are those caused by the action of the drug itself on the body. *Indirect* effects may result from the manner of taking the drug, the lifestyle of the user, or other factors.

Direct long term effects of amphetamines include:

a) **Tolerance** — increased doses are needed to achieve the same degree of effect. Tolerance does not develop to all effects at the same rate. It is still not entirely clear whether cocaine produces tolerance in humans, but medical observations suggest that it does.

b) **Dependence** — the user feels a compelling need to keep taking the drug. Experiments with animals have shown that when there is a free choice, amphetamines and cocaine will be used in preference to all other drugs. Animals addicted to amphetamines and then withdrawn will work very hard to get more of it, and will keep trying about twice as long as similar animals addicted to heroin and then withdrawn. If amphetamine use is suddenly stopped, the heavy user shows withdrawal symptoms which include fatigue, long but disturbed sleep, irritability, strong hunger, and deep depression that may lead to attempted suicide. Fits of violent action may also occur. These disturbances can be temporarily reversed by taking the drug again.

c) **Psychosis amphetamine** — mental disturbance very similar to paranoid schizophrenia. It is an exaggeration of the short term effects of high doses. Usually the symptoms disappear within a few days or weeks after the drug is stopped.

Indirect long term effects include:

a) **Malnutrition** — because amphetamines suppress appetite the regular, heavy user may fail to eat properly and thus may develop various illnesses related to vitamin deficiencies and malnutrition.

b) **Increased susceptibility to disease** — due to a generally rundown condition, lack of proper diet, lack of sleep and, often, an unhealthy environment.

c) **Violence** — heavy users of amphetamines may be prone to sudden violent acts, often for no apparent reason. This results from drug-induced self-centredness, confusion, distortions of perception, and from the deviant lifestyle of many users. In one Canadian study, violence (accidental, self-inflicted, and attacks by others) was the leading cause of amphetamine-related deaths. Violent death was at least four times as common among regular users of amphetamines as among non-users of the same age and sex.

d) **Multiple addictions** — amphetamine users may turn to other dependence-producing drugs as one means of coping with undesired amphetamine effects. In particular, depressant drugs such as barbiturates and heroin may be used as an aid to sleep or to compensate for overdose, sometimes resulting in an addiction to these drugs as well.

e) **Infections** — may occur from the use of unsterile needles for intravenous injection, or from repeated injections at the same spot. Some infectious diseases are passed from user to user through sharing needles; hepatitis is very common among speed users.

f) **Blockage of blood vessels** — impure amphetamines often contain materials not easily dissolvable in water. These particles can pass into the body and block small blood vessels or weaken their walls. This, in turn, can lead to kidney damage, lung problems, stroke, and other tissue injury.

WHO USES AMPHETAMINES?

Although most people think of amphetamine abuse in connection with young people using illegally purchased drugs, many abusers first took the drug on a doctor's prescription and may still supply themselves by getting prescriptions from several doctors at once. Strict government controls on the prescribing of amphetamines and some related drugs reduced the medical use of these drugs in Canada by 90% in 10 months.

Amphetamine abuse may result from increased doses being taken to overcome tolerance to some of the effects. Many users are ignorant of the risks involved.

AMPHETAMINES AND THE LAW

Amphetamines are controlled drugs under Schedule G of the Food and Drug Act, and are available to the consumer on prescription. They are also restricted at the manufacturing and distribution levels by being available only from firms licensed by the government to deal in them.

Anyone violating the provisions of the Food and Drug Act by trafficking in Schedule G drugs or possessing them for the purpose of trafficking is guilty of an offence punishable by a maximum term of 10 years imprisonment.

The Journal

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1976 Alcoholism and Drug Addiction Research Foundation

Clip this page

New Books

by RON HALL

Psychodynamics of Drug Dependence

. . . edited by Jack D. Blaine, and Demetrios A. Julius

One objective of this monograph is to stimulate the development of new research directions and strategies for implementing innovative treatment which take into consideration psychiatric evaluation and psychodynamic understanding. The papers presented are an initial effort by a group of psychiatrists to address the relevant issue, and they range from the theoretical to the clinical, and from broad-scope issues to precise, limited studies. Papers include: ego functions in drug users; psychiatric aspects of opiate dependence; transference phenomena in the treatment of addictive illness; the ego, the self, and opiate addiction; self- and object- representation in alcoholism and other drug dependence; and implications of psychodynamics for therapy in heroin use.

(National Institute on Drug Abuse, 11400 Rockville Pike, Rockville, Maryland, 20852. 1977 198p.)

International Statistics on Alcoholic Beverages Production, Trade, and Consumption 1950-1972

. . . The Finnish Foundation for Alcohol Studies

This volume represents a compilation of tables of international statistics concerning alcohol consumption. The intention of this report is to provide systematic statistical information on world production, trade, and consumption for all alcoholic beverages during the period 1950 to 1972, and to identify some of the most important technical and methodological problems encountered in a statistical investigation of this kind, to assess the present status of international statistics for alcohol, and to present a model for further work in this field. Definitions of the terms used in the report, and a description of the methods and procedures used in the compilation of data are provided. Technical and methodological problems are discussed, and sources of the data are indicated.

(The Finnish Foundation for Alcohol Studies, Kalevankatu 12, 00100 Helsinki 10, Finland. 231p. $8.)

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Marketing Dept (595-6056)
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½ Page (560) lines	$300
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Circulation: 10,019
(Ontario, 6,718; other provinces, 711; USA. 2,320, foreign, 270). Bulk, 3,000; Media 1,093

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Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six point scale. For further information, contact Linda Chung, coordinator of the group at (416) 595-6150.

The Campus Year Book

Subject Heading: Youth and alcohol, drugs and youth.
Details: 20 minutes, film strip, color, sound.
Synopsis: Another of the five-part series from the Hazeldon Alcoholism Chemical Dependency series, this cartoon film strip describes how the use of alcohol and pills affect young people's lives. As an elderly camel sweeps up beer cans and pill bottles in a high school, he relates countless stories of pupils who have either been destroyed by their dependency on chemicals, or who have admitted their problems, sought help, and managed to get back on their feet again.
General Evaluation: Poor to fair (2.7). A contemporary, but somewhat boring film strip, it received moderate ratings in all other categories such as informativeness, technical quality, and usefulness as a teaching aid.
Recommended Use: Could be used with general audiences of 12 to 18 years of age.

To Meet A Need

Subject Heading: Employee assistance programs.
Details: 9 minutes, 16 mm, color, sound.
Synopsis: Employee assistance programs have been designed to identify and help those people who are having problems which result in poor work performance, including chronic absenteeism, and lateness. Problems can affect anyone regardless of sex, age, or position. It is important that programs be a joint effort of labor and management.
General Evaluation: Good (3.8). A contemporary film with a clear message, the film received moderate ratings in all the other categories such as effective teaching aid, informativeness, interest level, and technical quality.
Recommended Use: Likely to benefit adult audiences.

ADDICTION RESEARCH FOUNDATION NEW RELEASES

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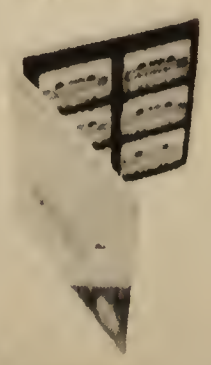
AT-013 CHANGING THE DRUG DEPENDENT LIFESTYLE
21 minutes *by Anne McKay*
Lifestyle change is a difficult challenge facing alcohol and drug abusers. Anne McKay, formerly an occupational therapist with the Addiction Research Foundation of Ontario, discusses leisure related problems, leisure counseling, and the basics of a leisure service. Program planners, counselors, occupational therapists, and recreationists should find this information useful, not only in assisting alcohol and drug abusers but also in developing preventative mental health, pre-retirement, community re-entry, and other lifestyle change programs.

AT-014 SOLVENT AND AEROSOL ABUSE
25 minutes *by Alec Gabe, Frederick Glaser, and Adrian Wilkinson*
What are solvents and aerosols? Who abuses them and why? What can the community do about it? These questions and others are explored in a wide-ranging discussion including Mr. Alec Gabe, information counselor; Dr. Frederick Glaser, head of psychiatry; and Dr. Adrian Wilkinson, clinical psychologist; all with the Addiction Research Foundation of Ontario. Approaches to the management and control are presented along with a discussion of the evaluative process.

AT-015 DRINKING-DRIVING COUNTERMEASURE PROGRAMS
24 minutes *by Pamela Ennis*
The focus in this presentation by Dr. Pamela Ennis, a scientist with the Addiction Research Foundation of Ontario, is on drinking-driving countermeasure programs. Strategies of primary, secondary, and tertiary intervention are considered and their effectiveness is discussed in the context of general and specific deterrence.

OTHER CURRENT TITLES

AT-001 PREGNANCY AND DRUGS *by Barbara Tucker*
AT-002 FAMILY THERAPY *by Reesa Kassirer*
AT-003 WOMEN AND PSYCHOTROPIC DRUGS *by Ruth Cooperstock*
AT-004 COUNSELLING THE CHILDREN OF ALCOHOLICS *by Kathleen Michael*
AT-005 DETOX CENTRES — THE ALTERNATIVE *by Dianne Hobbs*
AT-006 COCAINE *by Oriana J. Kalant*
AT-007 CONTROLLED DRINKING CONTROVERSY *by Norman Giesbrecht*
AT-008 THE WOMAN AND HAZARDOUS DRINKING *edited by Deborah Levine*
AT-009 TEENAGE DRINKING: USE AND ABUSE OF ALCOHOL *by Reginald G Smart*
AT-010 EMPLOYEE ASSISTANCE PROGRAMS: An Overview for Employers *by Bryan White*
AT-011 OUTPATIENT TREATMENT OF THE ADULT ALCOHOLIC *by Michael Jacobs*
AT-012 DRUGS AND THE TEENAGER *by Dana L. Farnsworth and Michael Jacobs*



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Coming Events

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Canada

Detox Workers Training Program — Feb. 20-24, April 24-28, 1978, Toronto, Ontario. Information: Diane Hobbs, coordinator, Detox and Rehabilitation Programs, Addiction Research Foundation of Ontario, 33 Russell St, Tor, Ont, M5S 2S1.

10th Banff International Conference On Behavior Modification — March 19-23, 1978, Banff, Alberta. Information: Donna Fraser, coordinator, Banff International Conference on Behavior Modification, 603 733-14th Ave SW, Calgary, Alta.

Canadian Conference On Social Development — June 18-June 22, Vancouver, British Columbia. Information: Yolande Lachapelle, 1978 conference coordinator, The Canadian Council on Social Development, Box 3505, Station C, Ottawa, Ontario, K1Y 4G1.

Alberta Alcoholism And Drug Abuse Commission Summer School on Alcohol and Drugs — Sept 22-23, 1978, Kananaskis, Alta. Information: Marg Bailey, AADAC Community Extension Services, 2nd floor, 812-16th Ave SW, Calgary, Alta, T2R 0T2.

13th Annual Conference of the Canadian Addictions Foundation — Sept 24-29, 1978, Calgary, Alberta. Information: Stuart Hutton, conference manager, Action Plan '78, 812-16th Ave SW, Calgary, Alta, T2R 0T2.

United States

American Association For The Advancement of Science Annual Meeting — Feb 12-17, 1978, Washington DC. Information: American Association for the Advancement of Science, Dept R, 1515 Massachusetts Ave, NW, Washington DC, 20005.

3rd Annual Minority Drugs Workshop — Feb 16-17, 1978, Dallas, Texas. Information: Leonard C. Long, West Dallas Community Centers Inc, 300 Dallas West, Dallas, TX, 75212.

Alcoholism And The Family Workshop — March 18, 1978, Washington DC. Information: Dr Berman, Washington Psychological Center, 2139 Wisconsin Avenue NW, Washington DC, 20007.

5th National Drug Abuse Conference — April 3-8, 1978, Seattle, Washington, Information: NDAC-78, 200 Broadway, Seattle, Wash, 98122.

International Arctic Rim Conference on Alcohol Problems — April 16-20, 1978, Fairbanks, Alaska. Information: International Council on Alcohol and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

National Council on Alcoholism Annual Forum — April 27-May 3, 1978, St Louis, Missouri. Information: ICAA, Case Postale, 140, 1001 Lausanne, Switzerland.

Joint Conference of the American Association for Automotive Medicine and 7th International Association for Accident and Traffic Medicine — July 10-15, 1978, Ann Arbor, Michigan. Information: AAAM executive secretary, PO Box 222' Morton Grove, Illinois, 60053.

Abroad

4th International Conference on Alcoholism And Drug Dependence — April 9-14, 1978, Liverpool, England. Information: Merseyside, Lancashire, and Cheshire Council on Alcoholism, B 15, The Temple, Dole Street, Liverpool, L2 5RU, England.

International Conference on Alcoholism And Drug Dependence — May 22-26, 1978, Caracas, Venezuela. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

8th International Institute on The Prevention And Treatment Of Drug Dependence — June 4-9, 1978, Menton, France. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

5th Institute on Drugs, Crime, and Justice in England — July 11-29, 1978, London, Eng. Information: Arnold Trebach, director, Center for the Administration of Justice, The American University, Washington, DC, 20016.

ANNOUNCING

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A causeway of seated Buddhas leads up to the capital of one of the great temples in the ancient former Thai capital of Ayarthaya.

Thai addicts see monastery as 'wonder cure'

By Tony Garnier

THAMKRABOG, Thailand — The shock of walking into a Buddhist monastery packed with more than 500 heroin addicts, many obviously in considerable pain, isn't lessened when from the throng someone calls in perfect Oxford English: "I say old chap, do you play cricket?"

The comment, from a Burmese heroin addict, reflects the innumerable paradoxes of Thailand. Cricket is not played, but for some obscure traditional reason, newspapers carry results.

The Burmese youth related that he had learned English at a former British school, in the now socialist Burma, which had retained English teachers and traditions. "By jove, yes," he said enthusiastically, making the most of his first-ever chance to test his English on a foreigner.

The conversation took place at the foot of a rocky pass leading into steep hills 130 kilometres north of Bangkok, Thailand. Here can be found possibly the world's most unusual drug rehabilitation centre.

Using the Buddhist monastery Thamkrabog, herbs, and faith healing techniques, a priest (Phra Chamroon Panchan) claims to have cured 75% of 30,000 drug addicts who have visited him since 1962.

The marked differences between methods used at Sweden's Hassala community north of Stockholm, and Toronto's Addiction Research Foundation, and New York's "Daytop" complex, vanish when compared with those adopted at Thamkrabog.

In recognition of his work, Phra Chamroon last year received from the Philippines the Magsaysay Award, Asia's equivalent to Sweden's Nobel Peace Prize.

However, he was unable to travel to Manila for the presentation because of a vow made by all monks at Thamkrabog that they travel only on foot.

When opium was banned in Thailand in 1958, the monks at the monastery expected the then estimated population of 250,000 addicts would require considerable help.

A former Bangkok policemen, Phra Chamroon, was assigned the job. Some months later, four long-standing opium smokers demonstrated they had been cured at the monastery.

But instead of encouragement, Phra Chamroon and two other monks were accused of being communists and harbouring drug addicts.

Twenty months of persecution followed, including a Bangkok "trial" to which Phra Chamroon walked the 130 kilometres under a police escort. The reason for the escort was that "communist supporters" might launch an attack to free him.

Now, 16 years later, many of the addicts who arrive daily for the 10-day detoxification "wonder cure" come from Laos and also from Burma. On the day of my visit, of 550 addicts, more than 150 came from the Golden Triangle area. The rest, the majority, were mainly from Bangkok.

With the number of addicts in Thailand now estimated by most authorities to be between 500,000 and 600,000, the monastery is under considerable pressure.

Terms of entry are strict — anyone may come (including foreigners) unless they have been forced to take treatment against their will, have come for a second time, or are unable to keep vows laid down by the monks.

On entry, with the exception of basic toilet items, personal effects are locked away.

A pair of red shorts and a white T-shirt are issued.

In the presence of the Abbot, newcomers make a *Sajja*, or vow of allegiance to themselves, never to use drugs again and "call upon the spirits within themselves to witness this vow."

Considerable emphasis is placed on the vow-taking to put the addicts in what Phra Chamroon termed "the right psychological mind." Under Buddhist practice, the highest goal is to achieve freedom of the mind; ie freedom from defilement (Kilesa), and clingings (Tanha), and attachments (Upadana) of every type.

Vow taking in public puts group pressure on addicts not to succumb to the craving for a shot, an intense desire which will develop over the next few days.

During the first five days, addicts take a ritualistic steam bath and small cup of Phra Chamroon's herbal medicine (not more than 30cc per day). The medicine is made from 100 varieties of plants according to a recipe provided by his aunt, he said in an interview.

After taking the "medicine", addicts are encouraged to drink literally gallons of water, forcing them to vomit repeatedly.



Phra Chamroon (left) with elderly Thai heroin addict.

The second day is the toughest. Intense pain sometimes has to be endured as the detoxification process sets in. In these cases, a laxative is administered, partly to activate bowel movements and to help induce a deep sleep.

However, an authoritative Thailand medical source indicated that deaths have occurred at this stage. Also, especially in past years, successful efforts to smuggle morphine or heroin into the monastery had occured, he said.

Asked what the "official" attitude was to the centre, he said Phra Cahmroon was supported by many influential people in Thailand's society, especially in the military, even though it was not until after he won the award that a Government grant — $50,000 — had been given.

It was also claimed that the known relapse rate is 25% and a proportion that could be as high as 5% of all addicts admitted may have subsequently died under duress. Some believe this is mainly because when a former addict returns to taking heroin he invariably begins where he left off, taking a large dose immediately rather than gradually working back to his former tolerance level.

Though Phra Chamroon and his method have come in for considerable criticism in some sectors of Thailand, his commitment to doing what others claim a wish to do but don't have the will power to achieve, provides a remarkable insight into human achievement.

Phra Chamroon is of humble origin. The son of a herbalist, brought up in a provincial town, he began his working life as a clerk in the Ministry of Interior. He soon left to join the Bangkok police.

Through an interpreter, he told a fascinating tale of how, as a policeman, his inner feelings began to swell while he felt his body to be getting smaller.

As a policeman it was possible for him to punish bad people but he could do nothing to keep good people from going bad.

Finally the trigger to change the uniform of a policeman to that of a monk came when he was assigned to kill 30 communists.

In the Buddhist tradition, he asked his teacher what he must do to fulfil the order. But no matter how the "problem" was assessed, he couldn't escape the fact that he might succeed in killing 28, but that there would always be one or two who would survive.

"I didn't want to kill 28, I wanted to kill 30," he recalled. Instead of fighting the enemy by obeying orders he was ending up in a battle against himself.

So he presented his teacher with another question about how he could stop the "battle" going on inside himself.

The answer was that he was to take a vow to abstain from alcohol for six months.

Phra Chamroon claims he doesn't know why this answer was proposed, but he does admit that when he got drunk — which he frequently did when he was in the police force — he was capable of anything.

However, he took and fulfilled the vow. He didn't attempt to kill the communists. "They were arrested and killed anyway."

And even though Thailand has dubbed him as "the miracle worker" and others are sceptical, Phra Chamroon remains unmoved by either the praise or the criticism.

The real secret of his success rate, he suggests, is that he gives addicts — by example — a sense of self-worth and the will power to achieve what they wish to do.

Phra Chamroon is a perfectionist in everything he attempts.

THE BACK PAGE

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UN wants aid money to spend on drug control

By John Shaughnessy

NEW YORK — The General Assembly of the United Nations wants countries giving and receiving economic and social development aid to include drug control programs as part of the package.

Many programs aimed at reducing illicit cultivation of narcotic raw materials require socio-economic development in order to be successful. The General Assembly says such programs merit support from governments and international agencies concerned with providing aid for economic and social development.

In a resolution, recently-passed, the General Assembly asked governments for sustained contributions to the United Nations Fund for Drug Abuse Control (UNFDAC). It stressed due consideration be given to the economic and social development provided in drug control programs financed by the fund.

The resolution urged "all international or multilateral organizations and institutions concerned with providing economic and social development aid to cooperate with the United Nations by supporting financially the implementation of such drug control programs which include sectors dealing with the economic and social development of the areas covered by the programs."

The General Assembly's resolution seeking increased support for drug abuse control programs related to economic and social development is one of three related resolutions.

The other resolutions called for international cooperation in the treatment and rehabilitation of drug abusers; and intensified and coordinated efforts to fight the illicit traffic in, and illicit demand for, narcotic drugs and psychotropic substances.

According to Donald Smith, senior scientist in the International Health Services Division of Canada's Department of Health and Welfare, the fact the General

(See — UN — page 5)

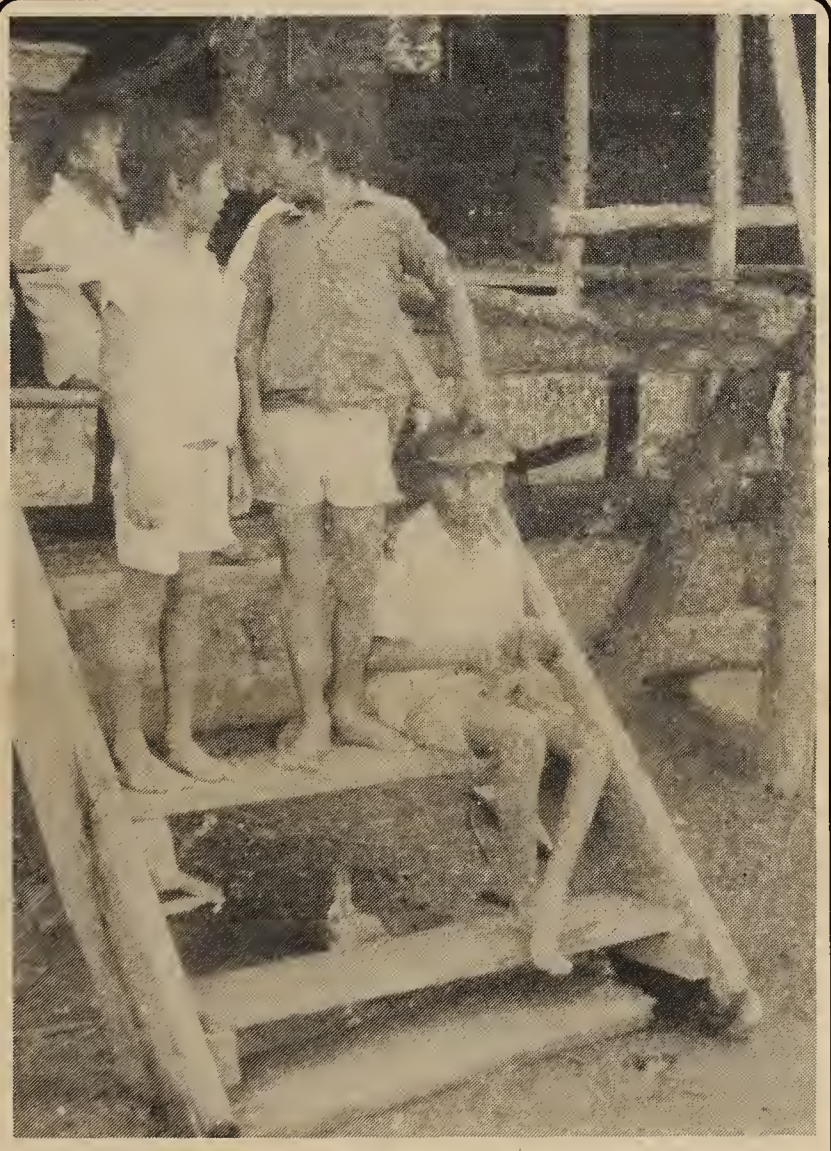
Canadian aid is not earmarked

OTTAWA — Canada's financial contribution to the international war on drug abuse is $200,000 a year.

Donald Smith, senior scientist in the International Health Services Division of the federal Department of Health and Welfare, told The Journal the $200,000 goes directly into the United Nations Fund for Drug Abuse Control (UNFDAC), from the Non-Medical Use of Drugs Directorate of the federal health department.

Canada does not earmark any of its contribution for specific projects such as treatment programs or law enforcement: "We have a say in how the money is spent, only insofar as we, as contributors, have a say in the way UNFDAC sets up its overall budget," said Dr Smith.

In the area of bi-lateral aid for the international control of drug abuse, Dr Smith said Canada's contribution is "essentially zero. Occasionally agricultural programs funded by CIDA (Canadian International Development Agency) might have an indirect effect on the production of illicit drugs, but there's certainly no committed or policy-directed use of funds for that purpose."



The Amazon and alcohol

By the time they are 12- or 13-years-old these children who live along the banks of the Amazon River will probably join their parents on sustained drinking bouts during the weekends. Alcohol is part of the social and economic fabric of life among river people and Indians. See The Back Page. Photo: Harvey McConnell

'79 bilateral fund

Mexican poppies are top US target

By Harvey McConnell

WASHINGTON — A request to Congress for $40 million for the 1979 fiscal year as part of the United States contribution to combating illegal drug production and trafficking has been made by the US international narcotics control program.

The request represents a $2 million increase over the $38 million being spent in the current fiscal year.

Mexico will continue to be the country receiving first priority for program money. This includes a requested increase on the $10 million being used there this year to fight drug trafficking, especially of heroin.

The campaign against Mexican opium production and heroin trafficking has been one of the most successful of the US programs.

Afghanistan, for the first time, would receive aid under the program. A request has been made for $500,000 to assist the Afghans in enforcement and crop control measures.

The American contribution to the United Nations Fund for Drug Abuse Control (UNFDAC) would be $3 million, the same amount as in the present fiscal year.

Under the 1978 budget, Latin America is receiving some $17 million for various programs, East Asia $5 million, and the Near East and South Asia $2 million.

International organizations, inter-regional programs, and program support and development account for the remainder.

Some 66% of the funds are being used for enforcement and control, 16% for international organizations, 12% for crop replacement, 3% for demand reduction, and 3% for program development and support.

The international narcotics control program is managed and administered directly by the Department of State, with advice and assistance provided by the President's cabinet committee on international narcotics control.

The focus of bilateral grant assistance is technical advice, training equipment and programs for law enforcement agencies, and monetary aid for crop substitution and related agricultural projects.

The largest multilateral item in the budget is financial support for UNFDAC.

Seven province survey:

Drunk drivers' deaths don't drop

By Bryne Carruthers

OTTAWA — Heavy alcohol consumption continues to be a major factor in fatal vehicle accidents across Canada, according to an analysis of 1976 statistics in seven provinces by the Traffic Injury Research Foundation.

The most striking statistics relate to snowmobile drivers: 60% had been drinking, and 52% were legally impaired prior to their fatal accidents.

Among 1,119 automobile drivers studied, 47% of the fatal victims had been drinking, and 38% were legally impaired.

Truck and van drivers, more in vogue these days, were found to have been drinking in 49% of the accidents studied, and were legally impaired in 42% of the cases.

Only tractor-trailer drivers, the professionals of the road, produced less obviously sensational statistics. Twenty five per cent of the victims had been drinking.

These statistics, at first glance, can be misleading, since all of the professional truck driver victims were legally impaired.

This suggests less impaired truck drivers managed to stay out of accidents more often than comparably intoxicated drivers of private cars or vans.

At the same time, however, the TIRF expresses concern about alcohol abuse among professional truck drivers, and recommends further research into the question.

Among fatal victims of motorcycle accidents, 40% of the drivers had been drinking, and 29% were considered legally impaired.

The TIRF says one significant change from previous years was a drop in the frequency of alcohol involvement among young motorcycle drivers.

This, the study suggests, could mean recent requirements for motorcycle training, as an example, had had beneficial effects. An in-depth study is urged into the impact of such courses as the collision behavior of motorcycle drivers.

The TIRF expressed some concern about the fact low levels of alcohol impairment seem to be proportionately more involved in motorcycle fatalities, compared to other vehicle types.

It suggests operating motorcycles may require levels and types of skills different from those for driving a car, and the statistics indicate such skills deteriorate more noticeably among motorcycle drivers at the lower alcohol blood concentrations.

Among automobile victims, males were drunk more often than females, (18% of females compared to 42% of the males). However, the percentage of women offenders has been steadily increasing in recent years, probably reflecting the increase in driving done by women.

As might be expected, young drivers were drunk more often than their elders. Fifty percent of

(See — Fatality — page 4)

Next month

The financing of programs to control drug abuse internationally is a major concern of the United Nations Fund for Drug Abuse Control, an arm of the United Nations Commission on Narcotic Drugs. Next month: reports from Geneva and the annual meeting in February of the commission, the highest international parliament in the drug field.

Inside

- *Wayne Howell* 2
- *Letters to Editor* 9
- *Around the World* 11
- *Factsheet* 13
- *New Books* 14
- *Projections* 14
- *Coming Events* 15

Number of Canadians who kick cigarettes on the rise



OTTAWA — The percentage of Canadians who are regular cigarette smokers continues to decline, according to the latest figures released by the federal health department.

The 1975 Canadian Smoking Habits Survey reveals 12% of one-time Canadian regular smokers have managed to kick the habit in recent years.

In 1975, 37.3% of Canadians older than 15 years of age were classified as regular daily cigarette smokers, down from 38.3% in 1974, and even higher percentages in previous years.

At the same time, and on a more pessimistic note, federal experts calculate 12% of all premature deaths in Canada can be attributed to smoking, representing a potential loss of 105,085 years of life among the affected Canadians. It's assumed Canadians statistically live to be 70 years of age.

Also, cigarette smoking costs Canadians $506 million, including $164.5 million in lost wages, and $56.1 million in total health care costs. The 1971 estimate is 20% less than the 1966 estimate.

The declining number of regular cigarette smokers is attributable mostly to the substantial decrease in adult male smokers.

The health department reports 43.3% of the males 15 years of age and older were admitted regular cigarette smokers in 1975, compared to 45.3% in 1974.

Since 1965, there has been an estimated 11% decrease in the percentage of regular male smokers.

Among female smokers, 15 years of age and older, the percentage has remained relatively unchanged at 31% between 1974 and 1975. In previous years there had been a slight increase.

Among teenage smokers there was a 1.6% decline between 1974 and 1975, to a level of 28.5%.

In 1975, more teenage boys (29.5%) than teenage girls (27.4%) reported smoking regularly.

Past inaction is assailed

Vigorous anti-smoking drives proposed for US

By Harvey McConnell

WASHINGTON — The congress and executive, the tobacco industry, and voluntary organizations, have been flailed for inaction on the hazards of cigarette smoking in a report by the National Commission on Smoking and Health.

The 22-member independent commission, following a year-long study of smoking and public policy, has recommended a vigorous plan which it thinks will help curb smoking.

The commission was set up by the American Cancer Society, but allowed to proceed independently. Members include three Nobel Prize winners, and medical, public health, and business leaders.

The report claims the US tobacco industry is essentially unregulated "and unaccountable to any agency of government for the content of its products or the health consequences of their use."

Despite the findings of the dangers of cigarette smoking, "the response to this problem by the federal government on both congressional and executive levels has been minimal and symbolic."

The commission thinks it is "a national disgrace" that the cigarette industry is not regulated.

'Smoking is a form of slow-motion suicide . . .'

The American Cancer Society itself comes in for criticism for not using "its potential resources to the fullest, particularly in the area of public policy."

The commission thinks the federal government should:

- Establish at cabinet level a commission on smoking and health.
- Direct the Food and Drug Administration to regulate cigarette additives, and have the tobacco industry held accountable for the safety of the product.
- Launch an anti-smoking advertising campaign by the Department of Health, Education and Welfare.
- Phase out the tobacco price support system over a 10-year period.
- Eliminate tobacco products from those which are exported under the Food for Peace program.
- Change the federal excise tax on cigarettes. There should be a higher and graduated tax based on the tar and nicotine content of a cigarette.
- Stop the sale of tax-free cigarettes at all US military establishments.
- Restrict the advertising of cigarettes which exceed a specific tar and nicotine level.
- Through the Department of Labor, support a policy for smoke-free places of work.

The commission believes state and local governments should do their part by limiting smoking in public places, restricting smoking in schools, and developing health education programs on the dangers of smoking and health.

Insurance companies could help by reducing premium rates for non-smokers.

The report by the commission was already in final preparation when Secretary for Health, Education and Welfare Joseph Califano announced a $23 million anti-smoking campaign by his department.

Mr Califano said smoking is a form of "slow-motion suicide" and "Public Health Enemy Number One in the United States."

Mr Califano called for a ban on smoking in airliners, sharper health warnings on cigarettes packets, and restrictions on smoking in federal buildings and many public places.

A recommendation to the Federal Trade Commission is that consideration be given to setting a maximum level of tar, nicotine, and carbon monoxide in cigarettes.

Conferences are being held with the treasury to study a differential excise tax which would be based on the tar and nicotine content of the cigarette.

Mr Califano said the most frightening of the statistics is the increase in smoking among young children. In one major city, one in five children aged 12 were smokers.

Some 14 million Americans, mostly white males, have given up smoking in the past 14 years. However, the rapid increase in smoking among teenagers, women, and minorities has helped keep the number of estimated smokers at 55 million.

Mr Califano said statistics by the National Cancer Institute estimated in 1977 smoking was a major factor in 220,000 deaths from heart disease, and 22,000 deaths from cancer of the mouth, throat, kidney, or bladder.

W Germany records 380 drug deaths

BONN — Some 380 people, most of them youths, died of narcotic overdoses in West Germany and West Berlin during 1977, according to federal police director Erich Strass.

Mr Strass estimated there are now 40,000 drug addicts in the country. Despite increased police activities against trafficking, this number is expected to increase this year.

'Use sex to sell sensible ideas?' Appalling!

By Wayne Howell



Ladies and gentlemen, tonight we have two distinguished guests who shall address the question: do governments have the right to co-opt the advertising techniques of private industry? For the affirmative, we are pleased to have professor E. R. Bottomsworthy, the noted social philosopher. And for the negative, we have A. B. Hucksterton, chairman of the Association of Private Advertisers. Would you like to lead off Mr Hucksterton . . .

"Thank you Mr Chairman. As you are aware, this question has arisen because of the shoddy attempt by the California government to influence public opinion by implying a man might be in a better position to score with a young lady by using alcohol in moderation rather than excess. The Association of Private Advertisers contends that governments have no legal or moral right to use sexual innuendo to influence the public: that is the exclusive perogative of private industry."

"Mr Chairman, surely Mr Hucksterton jests when he speaks of a legal right."

"I jest not Mr Speaker. Private industry has *possessory title* of the use of sexual stimuli to market products and lifestyles. We have used sex to sell automobiles, beer, shaving-cream, cigarettes, wine, hair-conditioners, snow tires, liquor, door-frames, and cocktail mixes; you name it and we have used sex to sell it, overtly, covertly, and subliminally, and we have been doing it for a lot longer than 20 years which is all it takes to acquire possessory title under common law."

"What balderdash Mr Chairman — possessory title is just a fancy word for squatters' rights: the right to play on the sexual fantasies of the public is not something that can be registered like a trademark. Just because the Association of Private Advertisers has been doing it for years does not mean others cannot play the same game. I submit governments have a perfect legal right to manipulate the public in this manner."

"But even if this were so Mr Chairman — and I for one cannot agree — surely governments have no moral right to do so. Governments should not indulge in the manipulation of public opinion by using sexual innuendo. It is both immoral and unethical."

"Mr Chairman, I must say I am amused by that last remark. How can the chairman of the Association of Private Advertisers presume to make moral judgements?"

"Because I am completely objective Mr Chairman; our association has no morals at all and as far as I know we never have had any. If anyone doubts that statement, then I invite him to watch the television advertisements we create for children. Who is in a better position to make moral judgements than the detached observer?"

"Such rhetorical speciosity I have not heard Mr Chairman. Let me speak to the moral issue: I contend the social costs of the lifestyles Mr Hucksterton promotes with macho Marlboro men and compliant cocktail cuties are considerable and ultimately they have to be paid by all the people.

"In view of this, governments are morally obligated to promote healthy lifestyles in the most effective way possible, and since over the years the Association of Private Advertisers has demonstrated the most effective way is to play on the sexual fantasies and insecurities of the populace, government is duty bound to go out and slug it out in the sexual trenches of media-land.

"I see nothing wrong with TV spots showing non-smoking, non-drinking men being mobbed by ravenous women who love their virile unpolluted bodies; I envisage Darlene whispering to Mary Jane in the washroom of a singles bar that the reason she always goes home alone is because of her tobacco breath; I envisage Susan telling Freda over a morning cup of coffee that although bourbon-breathing Bill has got the desire his excess diminishes his performance; I envisage advertisements as gross as 'did you get stroked today?' and as subtle and insidious as your average beer commercial. What's sauce for the goose is sauce for the gander — that's my position Mr Chairman."

"Do you wish to respond to that Mr Hucksterton?"

"I am shocked and appalled Mr Chairman. We will not allow this evil in our midst, which is why the wine lobby in California forced the government to cancel the kind of advertisement the professor so wistfully dreams of just 48 hours prior to air time. Governor Brown ordered the ads remade in a 'tasteful way'. Thank God there is someone who will stand up for decency, Mr Chairman, that's all I have to say."

(Wayne Howell is an Ottawa physician and freelance writer).

Teen drinking and driving at frightening level

By John Shaughnessy

TORONTO — Almost half of the 16-and 17-year-old drivers in Ontario high schools have driven their cars while under the influence of alcohol.

"The most frightening finding" in a recent survey of drinking and driving among Ontario high school students was 47% of the respondents aged 16 to 17 — who are underage drinkers — admitted they were drinking drivers on at least one occasion since becoming licenced drivers.

The survey of 1,801 students in grades 11 and 13 showed also approximately 23% of the collisions in which the students were involved were alcohol-related.

'The poor driving records of students may be indicative of more general behavioral problems . . .'

Since obtaining a licence, approximately 60% of the students reported having driven a car one or more times within an hour of drinking at least two drinks of alcohol. In fact, 34% of these drinking drivers admitted they had done this on 10 or more occasions. In the past year, about 58% drank and drove, and 32.4% of this group had driven, 10 or more times, within an hour after drinking two drinks.

Pamela Ennis, scientist, evaluation studies department, Addiction Research Foundation of Ontario conducted the survey. She said the respondents who admitted to having driven while under the influence of alcohol were more likely to have had accidents and been convicted of other driving offences.

Although students' knowledge about drinking-driving was fairly high, and they appeared to be aware of the danger to themselves and the public, more than 66% of the respondents agreed with the statement some people could drink alcohol and then drive safely, while 55.4% felt it was "okay" to drive after a few drinks of alcohol, but not "okay" to drive after many drinks.

Dr Ennis found several interesting relationships between drinking-driving and other variables. For example, grade average was not related to driving within an hour after having two drinks, or to the number of miles driven while under the influence of alcohol. But, students with higher marks were significantly less likely to be involved in an alcohol-related accident, not only as drivers, but also as passengers.

"A great deal more work needs to be done to sharpen the profile of the young driver. It may be that the poor driving records of many of these students are indicative of more general behavioral problems, such as disrespect for authority and the law, lack of control, or anti-social or aggressive tendencies," she said.

"Perhaps we should pay more careful attention to those who drink and drive at a young age, for they may pose the most serious driving risks in the future.



A survey of Ontario high school students reveals almost half of 16- and 17-year-old drivers have been behind the wheels of their cars while under the influence of alcohol. The survey shows also that 23% ofcollisions involving students were alcohol-related.

Women given blunt warning about pill and smoking risks

WASHINGTON — American women who both smoke and use oral contraceptives are being warned directly by the Food and Drug Administration of the increased risk they run of a heart attack or stroke.

Pharmacists, starting in April, will have to issue a warning leaflet whenever they fill a prescription for the pill. The leaflet has been drawn up by the FDA and based on the latest studies here and abroad.

It is estimated some four million American women both smoke and use the pill. Another estimated four million pill users are non-smokers.

The leaflet will state:

"Cigarette smoking increases the risk of serious adverse effects on the heart and blood vessels from oral contraceptive use.

"This risk increases with age, and with heavy smoking (15 or more cigarettes a day), and is quite marked in women over 35 years of age.

"Women who use oral contraceptives should not smoke."

FDA Commissioner Donald Kennedy said women who both smoke and take the pill "have a three times greater chance of dying from a heart attack or other circulatory disease than women who take the pill but do not smoke."

Dr Kennedy added: "If you take the pill, don't smoke. If you must smoke, find another means of contraception."

Studies have shown women who both smoke and use the pill have a five times greater risk of a heart attack than women who use the pill and do not smoke, and a 10 times higher risk than women who neither take the pill nor smoke.

A breakdown shows the annual risk of a heart attack in women who both smoke and take the pill is one in 10,000 in the 30 to 39 age group, and one in 1,700 in the 40 to 44 age group.

Among women who use the pill, but do not smoke, the risks are one in 50,000 in the 30 to 39 age group, and one in 10,000 in the 40 to 44 age group.

Among women who neither smoke nor take the pill, the risk is one in 100,000 in the 30 to 39 age group, and one in 14,000 in the 40 to 44 age group.

US drug agency revamped

WASHINGTON — Jurisdiction over narcotics traffic moving across the Canadian and Mexican borders into the United States will now be centered on two offices of the Drug Enforcement Administration as part of a major agency reshuffle.

In the past, these duties have been split between nine DEA offices.

The reorganization ordered by Attorney General Griffin Bell is aimed at putting more agents into the field. It will also make the agency more efficient, he said.

Mr Bell said 121 agents will be freed from desk work and able to operate in the field. The reshuffle does not mean any decrease in the 4,000 employees.

The reorganization is seen as a compromise move. A year ago, Mr Bell wanted to merge the DEA with the Federal Bureau of Investigation.

The number of regional DEA offices will be reduced from 12 to five. Supervisory offices will be located in New York, Chicago, Dallas, Los Angeles, and Miami.

Florida programs stymied

Many elderly women alcoholics dodge help

By Thomas Hill

PALM BEACH GARDENS, FL — Alcoholics among elderly women create a peculiar two-part problem for alcoholism workers, according to Eve Marsh, consultant, and former director of the Broward County Commission on Alcoholism.

One part of the problem is to identify them. The other is to persuade them to seek help.

The families of older alcoholic women are often aware of the alcoholism but frequently do nothing about it, through either shame or misplaced affection, Ms Marsh told a seminar here on Alcoholism and the Elderly. The seminar was held by the Alcoholism Education Council and some 18 cooperative agencies.



Eve Marsh

Doctors often aren't much help. They are usually loath to say "alcoholism is the problem" if there is any chance it might be normal senility. Thus, too many cases go undiagnosed, and there's need for more intensive case findings, Ms Marsh said.

Two treatment programs in Florida have reported approximately 50% of their patients are now women, and 20% of them are 65 and older. Ms Marsh said there's "a terrible need" to motivate the older alcoholic woman to seek treatment and recovery. One of the Broward County (Florida) outpatient services has reported calls for help come most frequently from lonely alcoholic older women in luxury condominiums.

"They'll talk for hours on the telephone," she said, "but they won't come in for help. They won't leave their homes. The humiliation and false pride are too great."

There's also denial. The attitude is they're just a little lonely. They "don't really drink too much."

While the majority of this type of call comes from lonely older women in condominiums, there are also many from welfare recipients who may be struggling with malnutrition as well as alcoholism.

'When a woman drinks excessively, it may be years before anyone outside of her family recognizes the problem . . .'

"We all know what comes first if there's a choice between food and liquor," said Ms Marsh.

An attitude that may prevent the elderly alcoholic woman from seeking help may be the reticence of family members to raise the question. They feel it might be "disrespectful to Grandma to suggest she's an alcoholic."

But age doesn't make much difference to the woman alcoholic as far as the pattern of her feelings and her emotions is concerned, Ms Marsh said. "Even a Grandma . . . perhaps even more a Grandma, can feel unloved and unlovable. As an older woman outside the mainstream, she can remain hidden. Her illness becomes one of alienation as much as of alcoholism.

"If she has depended on her husband's thinking, and she's a widow, she may have a problem trying to formulate her own thinking and opinions, and will have to struggle to attain her own identity. A protective circle of silence grows up around her drinking in an effort to protect her, and this perpetuates the cycle."

There's also the double standard. Ms Marsh quoted one author as saying: "When men drink excessively, they often get in trouble with their jobs or the law. When a woman drinks excessively, it may be years before anyone outside her family realizes the problem."

The divorce rate among women with alcoholism is high, and, again, there's a different attitude on the part of therapists and the lay public towards the woman and the man who divorce because of a a drinking problem.

"The non-alcoholic spouse of the drinking male is suspected of contributing to her husband's drinking," said Ms Marsh. "But the non-alcoholic spouse of the alcoholic female is more likely to be regarded as a deprived person, one who receives more sympathy than censure."

Some of our cultural attitudes in our youth-oriented society are a contributing factor to alcoholism in the elderly woman, Ms Marsh said.

In this connection, she referred to a Connecticut study which found one of the most numerous groups of alcoholic patients were elderly women from eastern European countries, who had important matriarchal positions in their native countries, but were isolated and disregarded in a contemporary American setting.

The contribution of boredom and lack of meaningful activity to alcoholism in the elderly is well known, Ms Marsh said, but there's also some tendency among older people in ill health to cut down on their drinking. This tendency is more marked among women.

One of the tragedies in dealing with the elderly alcoholic woman is that because of her age she may be excluded from some alcoholism services, while because of her alcoholism she will undoubtedly be excluded from many old-age services.

Constitutional challenge

Court is asked to squelch possession law

By John Shaughnessy

AJAX, ONT — The legal position of Canadians possessing marijuana may ultimately be decided in the courtroom.

Federal legislators have spent years studying the marijuana problem and apparently are in no hurry to change existing legislation (**The Journal**, Feb).

But, in a recent court case, a Toronto lawyer challenged the constitutionality of the marijuana legislation, and he says if the challenge is successful, possession of marijuana would be legal in Canada.

In the mid-January case, the federal prosecutor had asked the court to dismiss a charge of possession of marijuana against the accused. But defence lawyer, Ed Brown, said he was prepared to admit his client was in possession of marijuana when he was charged last Oct 1, and proceeded to make his constitutional challenge.

Mr Brown, a member of NORML (Canada), argued Parliament arbitrarily included marijuana as a substance under the Narcotics Control Act: "If Parliament declared oranges a narcotic, one could find oneself in prison for seven years for possession of an orange," he said.

To support his argument, Mr Brown called a pharmacologist to testify marijuana is not a narcotic pharmacologically, medically, chemically, or scientifically.

Michael D. Willinsky, pharmacologist, University of Toronto, said drugs are classified in relation to the set of effects they have on a person. Marijuana is pharmacologically and medically classified as a sedative-hypnotic and not as a narcotic: "Legally, marijuana is a narcotic only because it is included in the schedules of the Narcotics Control Act."

Mr Brown claimed the matter was a constitutional issue and said the case should be adjourned for further submissions because it involves civil liberties and the Canadian Bill of Rights.

Provincial Judge Donald D. Dodds agreed to adjourn the case until May 4 for further submissions from Mr Brown and federal prosecutor Russell Murphy. Judge Dodds said he believes the challenge is the first of its kind in Canada.

Alcohol programs for women 'work in vacuum'

WASHINGTON — Alcoholism among American women has been underestimated and state and local programs have operated in a vacuum in trying to help them.

The major need, according to Jonica Homiller, is for state and local alcoholism agencies to research the problem so the scope and nature can be better understood.

Ms Homiller makes a number of suggestions for change in a guide she has written for state and local officials, and prepared for The Council of State Authorities of the Alcohol and Drug Problems Association of America.

She points out those working in the alcoholism field must realize the problem among women "is different than among men in its etiology, manifestations, and required treatment response. In a similar vein, all women alcoholics are not the same in their problems and needs."

This uniqueness requires development of different treatment, prevention, intervention, education, training, research, and evaluation efforts.

Ms Homiller calls for state agencies to promote the hiring of women on all levels. Consideration should be given to establishing an office dealing with women's concerns, which would have its own budget and staff.

Experience has shown states which currently have specific staff for women's issues are those where there is the greatest level of activity.

Ms Homiller says the recommendations she makes "underscore the severity of the problem.

"It is time for the alcoholism field to take some action in effectively addressing alcoholism among women. It is appropriate — even critical — to start that action at the state and local levels."

Heroin-linked deaths drop

WASHINGTON — A vigorous opium poppy eradication program in Mexico has led to an estimated 40% drop in heroin-related deaths in the United States during 1977, says Peter Bourne.

Dr Bourne, director of the Office of Drug Abuse Prevention (ODAP), said "truly remarkable progress" has been made by the joint efforts of the US and Mexico. An estimated 47,000 fields of poppies, comprising about 14,000 acres, were destroyed last year.

Dr Bourne told the Senate Judiciary Committee: "There has been a decrease in heroin availability in our country.

"The heroin that is available is less pure; the price has gone up; and, most importantly, there has been a 40% decrease in heroin overdose deaths during the past year."

He said the flow of heroin into the United States last year was probably at its lowest level in seven years.

Dr Bourne stated: "The efforts taken in Mexico to destroy narcotic raw materials, such as the opium poppy, before they enter illicit channels, are the most effective and most cost efficient means of decreasing the flow of drugs such as heroin into the United States."

Virginia rejects raise in pack tax

RICHMOND, VA — Cigarette bootlegging from Virginia to the northeastern American states will carry on as usual, after an attempt to raise tobacco taxes was defeated in the state legislature.

Delegate Bernard Barron tried to get the tax raised from two cents to 4.5 cents a pack. He said the state gains an estimated $2.5 million a year in revenue from sales that enter the bootleg trade, but "we encourage and finance organized crimes in its efforts."

Cigarettes from Virginia are moved by the millions into states such as New York, where the tobacco is taxed 15 cents a pack.

Virginia produces almost 30% of all cigarettes manufactured in the US. The bill had been opposed vigorously by tobacco growers and manufacturers.

North Carolina has the lowest tax in the US, two cents a pack.



Non-smokers can finally find their way through the haze in Montreal. Two new handbooks, Montreal Without Smoke, and the Non-Smokers' Guide To Hospitals, were published in January by the Society to Overcome Pollution (STOP), a local environmental group. The books, produced by 10 university students on a summer employment project, were funded by Health and Welfare Canada, and the Non-Medical Use of Drugs Directorate. Montreal Without Smoke lists the smoking policies of different public places, and means of transit. The hospital guide rates 60 area hospitals on a four-star scheme. "Tobacco smoke, the major source of indoor air pollution, is a health hazard," it states, and "hospitals should provide a healthy environment."

Fatality high for drunken walkers

(from page 1)

those 16 to 39 years of age had been drinking, and 40% were legally impaired.

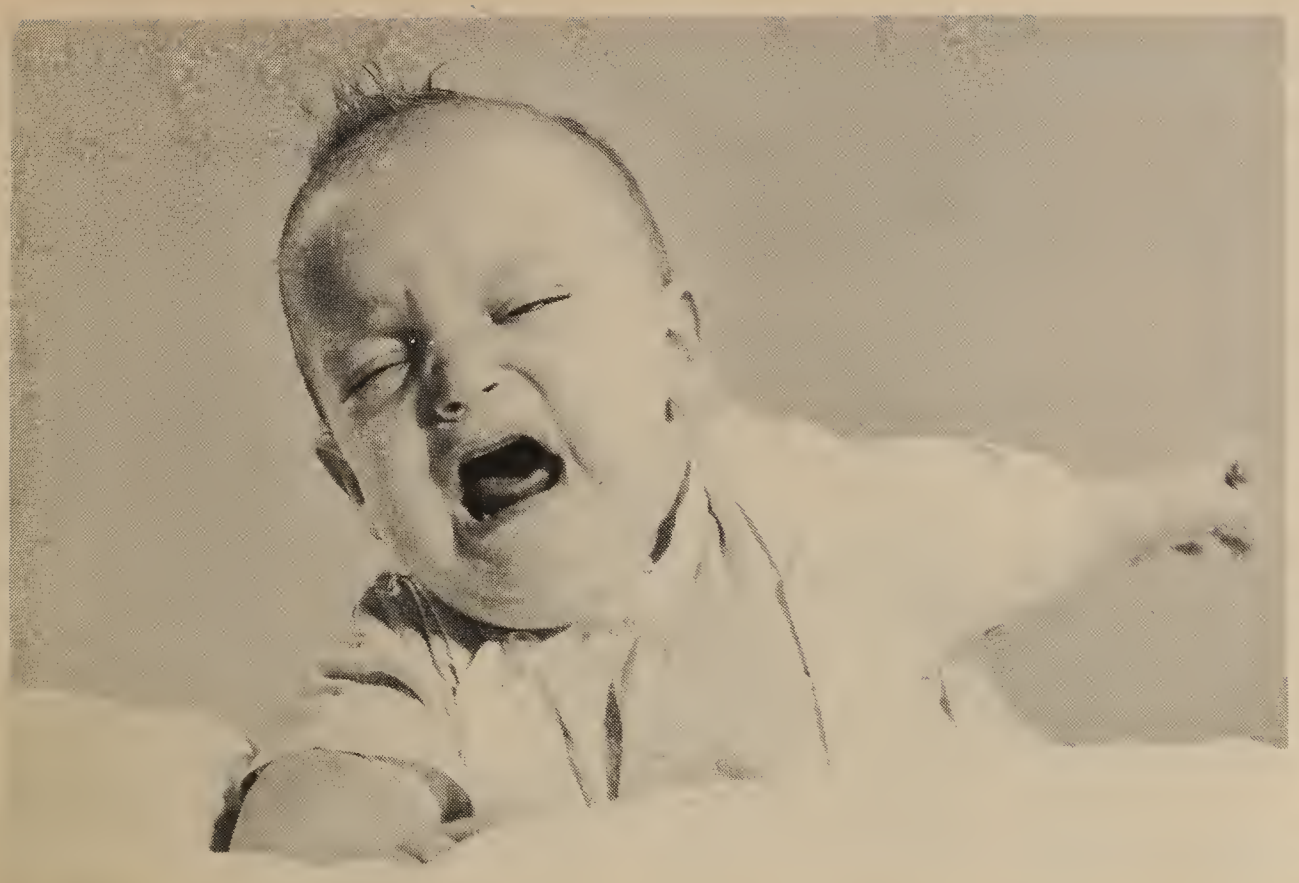
The younger driver category also accounted for the largest proportion of fatalities.

Overall, the TIRF reports there has been little change in the level of alcohol involvement in fatal traffic accidents.

Among pedestrians killed in such accidents, 43% of the 14 to 64 year-old group had been drinking, and 68% of the 18- and 19-year-olds had been drinking.

Generally speaking, fatally injured pedestrians were much more impaired than driver victims. For example, 35% of drivers and 57% of the killed pedestrians had alcohol levels in excess of four times the legal limit.

The statistics were collected from the provinces of British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, New Brunswick, and P.E.I.



Stimulating crying babies can cause behavior problems

LONDON — Babies could be turned into excitement addicts if they are entertained rather than soothed when they are upset, says a Cambridge University professor.

Insead of comforting a crying baby, and bringing him back to a restful state, today's parent picks him up, jogs him, shows him flashing lights, and points out this and that, said Professor Ivor Mills in an interview with *Mother* magazine.

He said when a mother keeps on stimulating her child, he may stop crying temporarily, but the long term effects are serious: "When this happens repeatedly, the child will sleep badly and become tired, irritable, and depressed."

As the child grows older, problems may increase: "The children I see who are causing trouble at home and at school are doing this purposefully to cause the excitement that experience has taught them will mask depression," said Professor Mills.

"They are like drug addicts who keep on increasing the dose and the effect until no amount of stimulation will produce the desired effect. Then they take an overdose. Totally desperate, they feel they cannot cope at all."

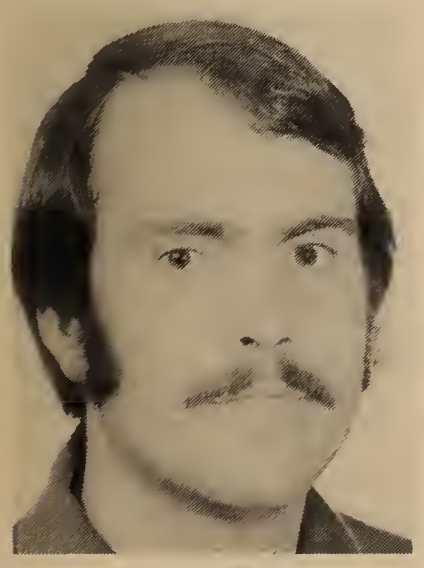
Alcoholics seeking help find gaps in system

By Manfred Jager

WINNIPEG — There is a serious discrepancy between the needs of alcoholics who have decided to seek help for their affliction, and the treatment programs they are actually offered.

Angus Reid, who has conducted research into the treatment of alcoholics across Canada, said the deficiencies manifest themselves in several ways. These include the relative difficulty of access to treatment for women: the narrow-spectrum care alcoholics with multiple social needs receive; the lack of flexibility and adaptability in treatment agencies; and the lagging ties between alcohol treatment programs and the Canadian health care system.

Dr Reid, assistant professor, department of social and preventive medicine, University of Manitoba medical school, did his research over the past two years on a number of federal health grants. He recently completed part of his report, a volume called Alcohol and Drug Treatment in Ontario: A Review of Current Programs.



Angus Reid

Dr Reid told **The Journal** he has identified five specific concerns regarding the treatment of alcoholism across Canada.

"The first of these issues concerns the link between the treatment programs, and the kinds of needs with which clients present.

"Just look at the evidence with women — the fact women are effectively excluded from large parts of the treatment system suggests there isn't as close a link as there could be.

> *'We find there are treatment agencies for the rich, and treatment agencies for the poor . . .'*

"The concern that I have, from a planning perspective, is that linking programs and needs of clients is emerging as a real dilemma in the alcohol and drug addiction treatment field. We have the suggestion we should have highly homogenous treatment agencies, that we should have treatment agencies for executives, for lower-class people on welfare, and the two groups should not mix in a treatment agency.

"This runs against all the egalitarian notions that work elsewhere in the country's health care system. We find that there are treatment agencies for the rich, and treatment agencies for the poor, and that the agencies for the rich have far larger publicly-financed budgets than those for the poor. These are expensive agencies, which go into the short-term residential type of care, and have a clientele of higher educational and income background than the other agencies."

Dr Reid indicated this criticism applies less to Manitoba than it does to some other Canadian provinces.

He said his second concern deals with the link between the alcohol and drug treatment system, and the more general health and social services system.

"The basic issue here is most people who want treatment don't only require treatment of alcoholism. They come in with a cobweb of troubles, problems and difficulties which span the entire health and social service spectrum. The case files are full of people who come forward having monetary problems, problems at home, in their marriage, with legal aid, and so on.

"For these people and all their hard-core problems we have generated a system of help which is far too highly specialized, and which just looks at one tiny slice of their difficulty — the one that relates to their drinking. That's why the question of linking their drinking to the health care system is so very important.

"In the final analysis, it seems to me the ultimate success of a treatment program may not be so much what it does internally, but how capable it is of giving the client linkage to other resources in the community."

Dr Reid said 118 of the 141 treatment agencies he researched in Ontario have no staff to find out what happens to clients after they receive treatment for their alcoholism.

He said the third shortcoming he has discovered relates to the ability or lack of ability among alcohol treatment agencies to mobilize community support for their work, and for their clients after these have received treatment.

> *'Hospital-based alcoholism programs are particularly inflexible. These programs are caught up in so many constraints . . .'*

He said it seems certain types of agencies, perhaps because of their staffing, or type of treatment approach, seem more capable in this respect than others.

"If we say alcoholism is a problem which finds its roots within the community, with causes resulting from community pressures, and from community fragmentation, then part of the answer must ultimately come from the growing awareness of people in the community and from their attempts to solve alcoholism."

Dr Reid accused treatment agencies of being incapable of adapting to changes in their own field, the health field, and the community.

"This goes very much into policy issues. Many of the programs we have, have a lot of inertia once they are developed, an inability to change the kinds of things they are doing, an inability to try new things and so on.

"Organizational content tends to limit adaptability.

"Hospital-based alcoholism treatment programs are particularly inflexible. These programs are caught up in so many constraints. These people always have to check with nursing service, psychiatry and this and that before something out of the ordinary can be done, even for minor changes. I don't think we've been able to get a handle on that issue at all.

"Manitoba is a great example for this. We get several groups which come along, such as the Alcoholism Foundation of Manitoba, and they become less concerned with providing direct treatment and trying new approaches to direct treatment, and instead become involved in a lot of empire-building."

Dr Reid said his final concern is for the future of research into alcoholism treatment, and what direction it should take.

Agencies were asked what contribution research had made to their work: "At the national level, about half of the programs reported some involvement in program-related research, but about 20% claimed they hadn't even received the results of research projects. Even fewer felt the investigation was relevant to their programs.

"It seems to me this finding indicates we have to look at the kind of research we are doing in respect to alcoholism programs. This is especially a problem in Ontario, where you have a very curious situation. Most of the research resources are centred in the Addiction Research Foundation in Toronto. Yet we have most of the programs carried out by the Ontario Health Ministry. This split between program and research has created a number of serious problems."

UN assembly asks UNFDAC to head campaigns

(from page 1)

Assembly passed the resolutions indicates a growing concern about the health, social, and economic difficulties that are being encountered throughout the world because of illicit drug trafficking and use.

"The General Assembly set up the United Nations Fund for Drug Abuse Control in the early 1970s so you can't say it's just become aware of the drug abuse problem," said Dr Smith. "The recent resolutions reflect the General Assembly's conviction that minor housekeeping changes in existing programs are not enough, and a new push and drive is needed because of the increasing difficulties that are being encountered worldwide."

With respect to treatment and rehabilitation programs, the General Assembly is concerned efforts may be duplicated, and awareness of the dangers of drug abuse may be limited, if international cooperation is not made a high priority.

It has asked UNFDAC to initiate, in collaboration with the World Health Organization, and other appropriate agencies and bodies of the United Nations, actions to design models for prevention, treatment and rehabilitation, taking into account the diversity of cultures in which drug abuse exists. It asks also these agencies to study the feasibility of establishing training programs, and treatment and rehabilitation centres.

Further, the General Assembly wants appropriate agencies and bodies of the UN, as well as international or multilateral financial institutions engaged in development assistance, to cooperate with, and assist UNFDAC in the commissioning of pilot projects. These projects would aim at providing farmers who had relied on growing narcotics raw material as their principal source of income, with other ways and means of income in areas where the illicit cultivation and production of narcotics raw material shall gradually be eradicated in accordance with the decisions of the governments concerned.

In the same vein, the General Assembly has invited governments to consider including projects designed to promote economic alternatives to farmers and others who are dependent on illicit production of narcotic substances, as additional and integrated components in their economic development programs when applying for technical and financial assistance from multilateral institutions

In its third resolution, the General Assembly called for increased efforts to fight the trafficking in, and demand for, illicit drugs. It urged every government to intensify its fight against illicit drug traffic by providing law enforcement agencies responsible for intercepting the traffic in narcotic drugs with the best means of exchanging relevant information with similar authorities of other countries, and by cooperating with the international organizations working in this field.

With respect to the demand problem, the General Assembly asked governments to evaluate their drug prevention programs in order to assess their efficiency, as well as to expand and intensify research in the field.



Pakistan moves cautiously

Opium: the latest battle on Northwest frontier

By James Magee

GENEVA — Opium cultivation has been part of the scene in Pakistan for at least 1,000 years, according to some historians. So it is not surprising the steps being taken by the national government to bring the situation under control are marked by circumspection.

A major difficulty is most opium production is in the colorful northwest frontier province. This region, made famous by writers like Kipling at the summit of the British Raj, is today divided into three areas whose names tend to speak for themselves — the Settled Districts, the Merged Areas, and the Tribal Areas.

The territory covers about 25 million acres, but only about three million acres get enough rain or irrigation to grow crops — mainly wheat or opium.

The situation is well under control in the Settled Districts, according to an extensive recent inquiry. There, all the normal legislation of the country is in force, including the narcotics laws. Opium cultivation is under licence, and there are adequate land records.

In the Merged Areas, which were formerly ruled by princes whose main interest was in opium revenue, the government writ certainly runs, but there are no land area records or any form of documentation on ownership rights.

As any ex-colonel of the British Army in India could predict, the problems in the Tribal Areas, which stretch in a narrow belt along the frontier with Afghanistan, are much more than simply administrative.

"None of the ordinary laws of the country, including the narcotics laws, are applicable in those areas", said Khanzada Abdul Wadud, director of planning, Pakistan Narcotics Control Board, and co-author of the inquiry with Dr Inayat Khan, of the World Health Organization's drug dependence program.

Offical strategy is to extend administrative and legal control in a phased program, linked where possible by development programs which are impressive enough to bring about a change in thinking: "In fact, large areas are unfit for the economic production of crops other than the opium poppy, and income substitution projects must come first", Mr Wadud said.

Pakistan produces about 200 to 250 tons of opium annually, most of which goes to meet the needs of some 80,000 to 100,000 regular users. An additional market is created by the firm belief in the medicinal properties of opium, and, in fact, the majority of the prescriptions by the practitioners of traditional medicine (Unani) are based on the drug.

"In addition, opium is also considered a standard household remedy for a variety of chest and stomach ailments," said Mr Wadud.

Opium is not the only drug in use: "Although the drug abuse pattern among the older population is fairly stable, in younger groups it keeps changing. Amphetamines, barbiturates, the minor tranquillizers, cannabis — the spectrum is wide."

A major handicap in coping with the situation is the country's limited infrastructure in the health care sector. However, there is a gradual improvement.

In 1947, there was only one doctor in Pakistan for every 23,500 people, and infant mortality was more than one in five births. By the end of 1977, the ratio of doctors had risen considerably, but is still low — one for every 6,900 people. The manpower shortage in medical care is even more evident when it comes to treatment of the drug dependent.

"Today we have 30 psychiatrists for a population of more than 70 million, three years ago we had only 10. But if all the qualified psychiatrists working abroad returned, we would in fact have a staff of about 300."

One possibility being considered is to find a way of recruiting the traditonal healers, of whom there are about 60,000, to help wean drug users. This would require a certain amount of reeducation, since the Unani practitioners are inclined to be opium-oriented.

"But the quantities they use in their medicines are minute," Mr Wadud said. "And, if they were working with us, we could make a lot of progress. But the Pakistan Medical Council is very hostile to the idea."

A number of special units have been set up by the PNCB, whose tasks include law enforcement and intelligence duties, and the study of drug demand. Enforcement, said Mr Wadud, is not punitive in nature, and in fact the greater emphasis is on simply gathering information and statistics, at present sadly lacking.

As for treatment and rehabilitation, a number of pilot centres have been established in some cities. Plans are being drawn up also for public education programs: "But we are going very carefully, and will probably target on population segments at the start, the parents, for example; Mr. Wadud said.

At the same time, a joint UN-Pakistan project for agricultural substitution and improvement has been launched in Buner, a 700-square mile terrain in the Merged Areas, where at present, poppies are the staple crop.

Iran tightens up on opium maintenance for the elderly

By Lachlan MacQuarrie

HONOLULU — Iran is making a serious attempt to tighten up its opium maintenance program and to improve rehabilitation services.

M. R. Moharreri, Professor of Psychiatry at Pahlavi University and an officer of the National Iranian Drug Addiction and Rehabilitation Service, told the Sixth World Congress of Psychiatry here that in 1969 the Iranian Government initiated a nationwide opium maintenance program for addicts 60 years of age and older, and for those suffering from chronic diseases for whom detoxification was not advisable. Registered opium addicts were given coupons which would enable them to obtain an allowance of opium.

Unfortunately, according to Dr Moharreri, "non-registered addicts have been simply able to obtain their supplies from drug traffickers or from registered addicts who sell them a portion of their supply".

Another problem has been that some physicians who have authorized the issuing of opium coupons to addicts under 60 years of age have not always been consistent. Vaguely worded diagnoses such as, "muscular and joint pains", "nervous and mental disorders", and "length and severity of addiction", accounted for a high proportion of the special authorizations of opium coupons. The result has been that more than 50% of the registered addicts in Iran were under 60 years of age.

Dr Moharreri noted that additional defects of the program were that, "follow-up was not commonly done, and in-patient detoxification was the only treatment service offered to addicts. Centres were often located far from the homes of opium abusers most of whom lived in small towns and villages.".

Following strong recommendations from the Iranian medical congress held in 1975, the ministry of health and welfare has instituted a series of tighter controls which have drastically reduced the number of registered addicts. At the same time, outpatient treatment and detoxification centres have been opened in various parts of the country.

Dr Moharreri outlined the first year's operation of one of these centres, the Shiraz Rehabilitation Centre. A total of 643 patients were treated on an out-patient basis during this period, of whom about 75% entered a program of methadone detoxification. The remaining 25% were treated by an "opium pill" containing 80 mg of opium extract and 8 mg of largactil.

Of the 643 entering the program in the year in question, about 35% discontinued treatment prematurely, while 20% relapsed and 20% were successfully detoxified. The remaining cases have either dropped out of sight or have remained on methadone maintenance.

Alcohol/sedative mix could damage kidneys

VANCOUVER — Acute kidney failure can be added to the list of possible consequences of combining alcohol with sedatives or tranquillizers.

It is not a direct effect of the drug on the kidneys, but a type of kidney shut-down usually associated with crush injuries.

Adam Linton, professor of medicine at the University of Western Ontario, said in an interview at the Royal College of Physicians and Surgeons of Canada, he had seen eight such cases in a seven-month period. He thought the condition was now being more widely recognized.

"It can occur as a result of one binge if sedatives or tranquillizers are added to the alcohol." In some people, the blood pressure drops low enough to impair circulation to the large muscles in limbs, Dr Linton said.

As the muscle cells become ischemic, their membranes break down, releasing substances that are toxic to the kidneys. With proper treatment, damage to both muscles and kidneys is reversible, but without it, the condition can be fatal.

Dr Linton said this type of kidney failure from muscle damage was common during the second world war, when people were trapped in bombed buildings and their limbs were crushed.

One particularly serious recent case he saw was a man who had taken a tranquillizer after a significant amount of alcohol, and went to sleep with his legs over a rail.

Attraction to loners

Is the 'pin-ball wizard' a potential addict?

By Mitchell Beer

MONTREAL — A recent proliferation of penny arcades here, making more pin-ball machines than ever before accessible to children and youths, could turn some individuals into pin-ball addicts, who identify with the flashing lights the way "workaholics" derive their self-definition from their jobs.

City officials said statistics on the number of new arcades were not available.

David McKearnin, a graduate psychology student at McGill University currently doing research in the area of addictions, said recognition that "the basis of addictions is less pharmacological than social and psychological, opens the interesting question of whether other sorts of things are addictive in some sense."

Mr McKearnin, emphasizing his comments were not based on empirical data, said he has spent time observing children and adolescents who frequent arcades, "and it seems there are two chunks of kids who play — the loners and the groups."

For peer groups that happen to gather at an arcade, the emphasis is on being together and part of a group — "the competition, screaming, and yelling is an immediately satisfying experience almost independent of the pin-ball — the machine facilitates the pleasure but doesn't cause it.

"In terms of psychological effect, these are just groups out having a good time who choose to do it at an arcade."

Mr McKearnin said he worries a lot more about the loner, "because here is an individual who's doing it for a more internal reason . . . as that reason becomes stronger, be it a state of mind, a process of social withdrawal, or an inability to deal with other people, the individual's lack of interest or skills to engage in social behavior becomes stronger, as the addiction comes to be the only source of pleasure.

"As with drugs or horse-racing, the addiction takes over more and more of the individual's pleasure and self-identification."

Mr McKearnin said he would be more concerned about the loner, than if he saw the same individual "drinking a bit with his pals, rather than engaging in a solitary activity, with the bells and flashing lights as his only identification."

Whether his comments are "grossly overstated" or reasonably accurate, he emphasized, "this is an empirical question nobody has looked at."

When pin-ball machines were originally outlawed in Montreal, and then when they were brought back, "there was a big hoopla about moral fibre, but it was always based on a snap assessment. Unfortunately, there's been no systematic examination of the effects."

Mr McKearnin said he had predicted some of the new arcades would go out of business as the "novelty effect" wore off, but although one on a major downtown street has closed and another is selling all its equipment, he said the weather may have been significant in reducing the attraction of the flashing lights.

"For some people," he said, "going out to play pin-ball isn't premeditated in the same way as drinking or taking drugs. More often, people are seduced by the lights and the music, but with the temperature going down, people are less sensitive to these cues."



Banning drinking until 21 a useless gesture

WASHINGTON — Young people drink more alcohol in states where the legal age limit is 21 than in states where it is 18, a survey of high school students by Catholic University here has found.

Questionnaires filled out by 3,500 young people in five states showed 47% of high school seniors drink beer at least once a week in states where their drinking is illegal, while 42% do the same in states where it is legal.

James Rooney, assistant professor in the school of social service at Catholic University, said the efforts to make drinking before 21 illegal are worse than useless. Dr Rooney carried out his survey in high schools in Maine, New Jersey, New York, Pennsylvania and Vermont.

Heavy drinking, defined as at least two quarts of beer, one pint of wine, or six mixed drinks a week, was also higher among young people in states where the drinking age was higher.

Some 36% of the seniors said they drank this much in states where it is illegal, compared with 26% where the minimum drinking age is 18.

In the states with higher drinking ages, some 66% reported that drinking had interfered with their school work, given them a blackout or memory lapse, or involved them with the police. The figure was 63% in states with a lower drinking age.

Young women overall were found to drink less, in frequency and quantity, than young men. Conversely, the young women were more inclined to drink when it was illegal.

Policy journal planned in US

NEW YORK — A journal that is "wholeheartedly in favor of public health" may soon be available in the United States.

Milton Terris, who will be editor of the new *Journal of Public Health Policy* said: "It will be a journal of advocacy, and we will be defenders and protagonists of the public sector. We will seriously discuss policy, policy alternatives, and how to get policy implemented."

Dr Terris, from the department of community and preventive medicine, New York Medical College, told **The Journal** he decided to establish the new publication because he and many of his colleagues feel the major public health journals are oriented primarily towards data papers, and insufficient space is available for those concerned with public health policy.

"Furthermore, these journals tend to be timid about publishing papers that call for new approaches to strengthen government programs for prevention and medical care.

"Our new journal will provide a forum for serious analysis and discussion of urgent public health problems, and we will speak out editorially, as incisively and as effectively as we can, on major current issues affecting the health of the people."

At the present time, Dr Terris is completing arrangements for the editorial staff, and the formation of a group of editorial consultants.

Smoking speeds up heart blockage

By Jean McCann

MIAMI BEACH — A patient who smokes cigarettes is more apt to have quicker progression of coronary heart disease as seen in the most objective possible way — pictures of the coronary arteries themselves.

Using coronary angiography, Thomas Gaarder studied 146 patients with some obstruction of one or more of the three major heart blood vessels. The coronary arteries of those who smoked narrowed much faster than the ones of those who didn't, he told the annual meeting here of the American Heart association.

The effect was also the hardest in those who were the worst off: those who had two or three coronary arties blocked, rather than just one.

Furthermore, Dr Gaarder said, the effect of cigarette smoking was rapid: it was clearest in patients with fewer than 18 months between their first and second coronary angiograms. Even with so-called single vessel disease, however, smoking was a significant risk factor (patients averaged 20 cigarettes a day).

Dr Gaarder, assistant clinical professor of medicine at the University of Southern California's Rancho Los Amigos campus at Downey, said progression of disease was defined as an increase in narrowing of at least 25% in any major vessel, between the first and second angiograms.

He found single vessel disease patients, overall, progressed at the rate of 10% per year, while those with double vessel disease progressed at the rate of 24% per year. With three vessel disease, the rate was 33%.

This progression was matched with patients' risk factors, including blood pressure, cholesterol and triglyceride levels, exercise activity, fasting blood sugar, and cigarette smoking (pipe and cigar smoking was not considered in this study).

Tax bite on drug traffickers

WASHINGTON — Smuggling marijuana is certainly a business. Unfortunately, for those who engage in it, they can't save a tax buck or two in claiming "business expenses."

That is the decision by the US Tax Court here following two precedent-setting cases where the smugglers claimed tax deductions for "ordinary and necessary business expenses" when they got caught.

In one case, a Texas man, who grossed $780,000 in one year of smuggling, lost his claim for $55,000 trading losses and necessary expenses when agents confiscated a ton of marijuana, his pickup truck, and trailer.

In the second case, the president of an electric motor business in Texas claimed an expense deduction following his arrest with 180 pounds of marijuana, and confiscation of the company-owned Jaguar sedan.

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Anne MacLennan

STAFF WRITER/PRODUCTION EDITOR
Karin Pargas

CONTRIBUTING EDITORS
Harvey McConnell (Washington)
John Shaughnessy (Toronto)

SCIENCE EDITOR
Dr Ruth Segal

The Journal
Published by Addiction Research Foundation of Ontario
33 Russell St, Toronto, (416) 595-6053

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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Heroin withdrawal

Acupunture for addicts recomended

The following article is the first of a series in which members of The Journal's editorial board will comment on advances and controversies as they arise in their specialties. The opinions expressed are those of the author.

By David E. Smith

One of the services provided by the Haight-Ashbury free medical clinic is an acupuncture unit staffed by two traditionally trained Asian acupuncturists.

The acupuncture facility is located at the heroin detox and aftercare section of the clinic, and delivers approximately 22 acupuncture treatments a day. The clinic as a whole, which covers four different sections, sees approximately 200 client visits a day: half of them come to the drug detoxification and aftercare section for treatment of drug dependency.

Variety of conditions

At the clinic, we use acupuncture, with or without medication, for the treatment of heroin withdrawal if the patient requests it. In addition, we use acupuncture for a variety of other medical conditions, most of which involve pain. All acupuncture treatment is under medical supervision.

Relative to heroin detoxification, we found acupuncture, when used for the treatment of heroin withdrawal on an out-patient basis, is approximately as successful as non-narcotic medication for out-patient treatment of narcotic addiction, costs about one-third less, and doesn't have the associated problems of drug diversion.

Severe pain relieved

Recently, however, I have been very impressed with the use of acupuncture in the treatment of severe pain in abstinent recovering addicts. In part, this work has come about as a result of my growing association with Narcotics Anonymous, a self-help group that meets at the clinic, and helps us with the aftercare treatment of the addicts whom we detoxify and counsel.

In my 12 years of experience in the treatment of addiction, I have found one of the most perplexing problems that faces a physician is what to do when a using addict, or an abstinent, recovering addict, has true pain. For example, with the using addict, tolerance for opiates is very high, and you have to go beyond therapeutic dosages to have an analgesic effect, as well as be concerned with how your administration of opiates contributes to their current opiate abuse. Conversely, I have found the abstinent, recovering addict is more sensitive than normal to narcotic analgesic medication. In addition, there are many cases in which an abstinent, recovering addict who uses a chemical-free philosophy as a basis for staying clean, when administered a narcotic such as Demerol of codeine, in a medical setting, goes on a long opiate dependence run. This is somewhat the same as you see in Alcoholics Anonymous where an individual keeping sobriety based on total abstinence has one drink, finds his defences crumble, and then goes on a long alcohol abuse period.

A case in point demonstrates use of acupuncture for the treatment of pain in the abstinent addict; a 33-year-old recovering alcoholic/addict who achieved her sobriety and abstinence through dual participation in both AA and NA, was an active member in both of these organizations and is a member of the staff at the Haight-Ashbury Free Medical Clinic. She had a 10-year history of addiction, and, in recent years, has found her break from abstinence occurred around contacts with the health care system in which she received narcotic analgesic medication for pain.

She was extremely concerned she would slip back into a pattern of narcotic addiction when she had very severe root canal pain as a result of damage done to her teeth during her amphetamine and heroin abusing days. The dentist she was seeing, who was an excellent technician, prescribed codeine, despite the fact she indicated she was an addict and could not use any psychoactive drug, including the nitrous oxide he wanted her to take for analgesia.

Emergency case

Each time the physician wrote her a prescription for codeine, she would bring it to me as a precautionary measure to eliminate the temptation to use the medication. One evening, however, after our acupuncture unit was closed, she developed extremely severe root canal pain which disrupted her ability to sleep and to function. She made an emergency appointment with the dentist the next day. Since our acupuncture unit was closed, we decided we would try a few 100 mg Darvon N for pain relief to get her through the evening.

The next morning she told me she had an intense narcotic-like euphoria from the Darvon N and was concerned it would trigger an opiate run in her.

Following her examination by the dentist in the scheduling of a surgical procedure, she received acupuncture at our unit, and had significant relief of her pain.

Others should try

As a consequence of this experience, and as a result of my clinical experience, not just at the clinic, but with some of the recovering addicts in NA who have a total abstinence treatment philosophy, I am using acupuncture for all severe pain episodes, and am not prescribing narcotic-analgesic medication to the chemical-free recovering addict.

I find this approach to be extremely effective, and encourage other physicians who treat addicts to consider this alternative for the treatment of true pain in the abstinent opiate addict, as well as the tolerant, currently-using, opiate addict.

It is encouraging we are beginning to gain some insight into the basic mechanisms for the action of acupuncture. For example, recent research has indicated acupuncture anesthesia is partially reversible by Narcan, and it has been suggested acupuncture acts through the endorphins in a fashion similar to the narcotic analgesic. If this is the case, then the empirical success I have had in prescribing acupuncture treatment for pain in the opiate addict, is more understandable in western medical terms. I believe also the clinical success, and the better understanding of the mechanism of action of acupunture, will allow us to gain wider acceptance amongst drug treatment physicians who treat addicts, and I encourage practising physicians to consider this alternative as well as other non-pharmacological options when faced with the dilemma that I had and have described in this report.

Dr Smith is medical director, Haight-Ashbury Free Medical Clinic, San Francisco, and a member of The Journal's editorial board.



David Smith

'I believe the clinical success and the better understanding of acupuncture, will allow us to gain wider acceptance amongst drug treatment physicians who treat addicts . . .'



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Editor... Letters to the Editor... Letters to the Editor...

'Confidentiality' debates distort the issue

Alcoholism, and other forms of drug addiction in the workplace, are far too serious problems in our country to allow the provocative article written by Garry Briggs (**The Journal**, 1977 Dec) to pass without comment.

The author appeared to pay homage to the problem, but then distorts the real issues of how to achieve success in providing remedies and treatment, by concentrating upon the subject matter of the rights of the "worker" to confidentiality of information relating to his or her problem. The very mention of the denial of rights by invoking the War Measures Act shows the extent to which the author strays from the mark in making his point. None of this bears any relationship to the problem at hand, nor does it provide any methodology as to how the employer and the employee can come to grips with this serious problem.

Surely the author jests when he implies the real issue in solving addiction in the workplace lies in the granting of absolute privilege for all information and communication passed between an employee, and the counsellor, whose job it is to assist in the treatment and counselling of the addiction.

The issue of "privileged communication" only becomes a matter of practicality when an issue is taken before a Court of law, and then only relates to what evidence, if any, may be deemed admissible. How this issue then becomes a relevant matter of concern to those in the treatment and counselling field is more baffling than the sources from which Dr Briggs has gathered his material. I do, however, feel certain that Dr Briggs' own experiences as an alcohol consultant to the Public Service Commission in Alberta have given him some real insight into how a misguided program can become a liability to both the employer and the employee.

I submit it is more important to your readers to learn how properly structured programs of cooperation between management and labor can be implemented, with built-in safeguards for the employee, his family, and the employer, than to dwell on the dissenting issue of privileged communication. The real issue facing our country is one of inactivity in the implementation of such programs and the apparent lack of incentive for the parties concerned to face up to the realities of loss of productivity, loss of wages, loss of employment, and sometimes loss of life.

Was it the intention of Dr Briggs to convey to the readers that the union which he represents is dragging its feet on the issue of "privileged communication," when everyone else in the treatment field is concerned with the need to fund the creation of more and better programs?

Let's be more positive and find the right kind of incentive that will encourage an employee to seek help before it's too late, rather than create philosophical barriers to the development of effective employee-employer addiction treatment programming throughout our country.

Richard Anthony
Senior Crown Consul
Department of the Attorney-General
Victoria, BC

'A very fair picture' of developments at CAF

I have just recently read the February edition of **The Journal** and I wish to thank you, and specifically your writer, Karin Pargas, for presenting a very fair picture of what is happening with the Canadian Adictions Foundation. I appreciate the accuracy of the story, and would like to take this opportunity to update a couple cf matters as well as to check one error in the story itself.

Firstly, the story identified one of our staff as "Mr Glen Wilson." Actually, Mr. Wilson is Mr Wolfson. In addition, may I note that we have three people presently working in our central office: Mr Wolfson, who is the program coordinator and executive secretary; Ms Raun Kipp, who is manager of administration; and Ms Sheila Davids, who is special projects co-ordinator. As your story noted, they are very skilled people and are committed to the objectives of CAF.

Let me say that we have, even in the last few weeks, been able to cut some $4,000 off our deficit and have set our budget for 1978/79 at $90,400. At this point, the possibility of achieving a balanced budget by the end of March 1979 looks quite good.

The problems that the CAF is having are not new to national organizations. I note that recently I received information from a national organization to which I belong, and one which has thousands of members, noting that the executive director has had to resign and the executive offices are closed. In the case of the CAF, we hope that taking retrenchment action at this time will enable us to stabilize the financial situation and continue to direct the growth of the foundation.

I have been asked by some who wonder: "What good is CAF to us? What can it do for us?"

Let me say that the CAF has the potential of providing all of Canada with direction in the area of social policy, development and planning in the field of drug dependency. This is a big job that cannot be done overnight, and will certainly will take both time and skill. Moreover, it will also take tremendous effort in dealing with the political realities in order to have some impact on the politicians who make decisions regarding our lives.

Another way in which the foundation may be of assistance to Canada, and the field of drug dependency, is in the area of accreditation. I think the time has come to begin setting standards for both personnel and services in drug dependency programs. It would be a natural thing for the CAF to be involved in assisting this to happen.

These, then, are just two areas in which the CAF can and will have impact on drug dependency programs.

I believe the board's action in dealing with the reality of financial limitations suggests an awakening and a determination to make CAF a viable national organization.

Once again, many thanks for your efforts on behalf of the foundation. The board and I look forward to seeing all of you at the conference in Calgary in September.

Marvin M. Burke, RSW
President
Canadian Addictions Foundation

Therapy, discipline kept separate

I would like to correct a factual inaccuracy in your article Police/MD conflict needs sorting out (**The Journal**, Oct).

In the closing paragraph you indicated: "In California, a confidential treatment network has been set up so addicted physicians can be treated in private hospitals throughout the state. The state's board of medical quality assurance is informed by physicians being treated but the treatment and disciplinary aspects are kept separate so there's no risk of information, given by the addicted physician during treatment, later being used as evidence in a disciplinary manner."

In fact, our state's treatment effort is conducted to the California Society for the Treatment of Alcoholism and Other Drug Dependencies, and a collection of private hospitals and practitioners throughout the state of California, and is quite separate from the California state board of medical quality assurance.

The therapist treating the addicted physician does not report that practice to the state board, as this would violate a doctor-patient confidentiality and decrease the willingness of the physician to enter into treatment.

Conversely, the state board of medical quality assurance officially cannot take into consideration the fact that a physician is being treated in terms of other investigation as to his medical practice.

Unofficially, we have found that the board of medical quality assurance, however, in certain specific cases, is willing to defer prosecution of the physician if he makes a good faith effort to enter into drug treament.

Because this policy is unofficial, there can be no guarantee that such diversion action and treatment support will take place on the part of the state's board of medical quality assurance, but it does indicate a promising trend on the part of the state board of medical quality assurance to encourage treatment and rehabilitation, rather than prosecution as the initial effort for the addicted doctor.

David E. Smith, MD
Director, Haight-Ashbury Free Medical Clinic
San Francisco

'What is the state of Bill S-19?'

I am in total disagreement with the cannabis laws in effect in Canada today.

I have before me the January 1, 1978 issue of **The Journal**. On page 13, the Factsheet says; "Bill S-19 transferring cannabis to the Food and Drug Act, has been passed by the Senate and has had two readings in the House of Commons."

On page 1 of the February 1 issue the article "Liberal marijuana bill lanquishing," says "the legislation has already passed through the Senate side of Parliament, but has yet to make it to even an advanced state of consideration in the House of Commons."

These two articles contradict each other. Which is the truth, and where is Bill S-19 in our government?

In January 1977, I was told that Ron Basford, a Liberal MP and Minister of Justice, had introduced Bill S-19 as a private bill in November or December 1974.

About 10 weeks ago (December 10 or 11, 1977) I phoned Liberal MP, C. Turner's office in London, Ontario and asked him about Bill S-19. The next day I received a call from Mr Turner's office and was told that Bill S-19 was introduced early in 1975 and had been in Parliament for about 18 months but it had died.

Bill S-19 and the cannabis issue is something that needs your support as well as that of the Federal Department of Health and Welfare.

In the past year or so there has been a lot written on the medical benefits of cannabis and I have read that it is good for the teeth, cures glaucoma and could improve the treatment and condition of terminal patients.

In June 1972 and for a year or so after I was a regular at the ARF in London, I had a serious alcohol problem so I know what it is like to be addicted to a drug. I am proud to say that I have not had a drink since June 1972. I am convinced I am not involved with a drug that is more dangerous than alcohol.

But I am presently serving a nine month sentence for three possession convictions, "one gram of oil, four joints and two hits of LSD." I realize that the chance of me being caught, charged and convicted for more cannabis offences after my release in July is very good. Therefore I would like to offer myself as a subject to be studied to further the research of cannabis in Canada.

I am not asking you to make any moral judgements about pot. But the reality of the situation is that cannabis is here to stay the same as suicide, homosexuality, divorce and abortion.

How much longer will cannabis smokers in Canada have to wait before appropriate amendments such as those recommended by the LeDain Commission will come into effect?

James R. Hoad
Brantford, Ont.

No conflict

As stated in The Journal, February 1 (Liberal marijuana bill is lanquishing, p 1), Bill S-19 is now before a special interdepartmental committee of the federal government whose purpose is to modify the legislation.

The legislation must now be reviewed by Cabinet and then redrafted before it ean be resubmitted to Parliament.

Mr Hoad's confusion about the state of the bill is apparently due to a misunderstanding of how Canadian laws are passed, rather than to "contradictions" in The Journal. Bill S-19 was passed by the Senate and did go through two readings in the House of Commons, but before any bill becomes law it must successfully go through three readings in the House of Commons. Until a bill is passed for the third time, it can be revised, amended, shelved or defeated depending on the way the members of Parliament cast their votes. — The editor

Scope of coverage is found most impressive

You are to be complimented on the new format, and sturdy quality of paper to preserve **The Journal** more suitably for reference purposes. I especially value the wisdom evinced in your scope of coverage, both topically, and geographically.

At this writing, I am very interested in your interview with Mr (David) Archibald regarding the designation of ARF as an international "centre of excellence" (**The Journal**, Dec) by the World Health Organization.

Five years ago, the nutritionist Lester Brown of USDA, was ridiculed for expounding on the prospect of "depressing the availability of heroin" in that area. His optimism has since proved prophetic, for when the WORLD WCTU held their triennial convention in Australia last year, the principal guest speaker, Gilbert Rizzo from the United Nations, told us this prospect has come to pass in Thailand near the Burmese border, to wit:

These people whose subsistence crop had been opium poppies, are now being taught the techniques of agriculture. Production of the new cash crops in this program is very scientific ... lower land for lentil crops, and more elevated terrain for fruit trees and coffee. At any rate, these hill tribes are no longer planting poppies.

May your efforts be similarly successful. With 23 nations represented at our convention, the groundwork was laid for the current acknowledgement by drug dependence rehabilitation responsibility, "I think we ought to recognize that the drys ... the WCTU and others, have been correct in many of the things they have said for more than 100 years."

Marian B.S. Crymes
Washington correspondent
National WCTU
Washington, DC

Russian ministries squabble over cigarettes

By Thomas Land

GENEVA — Proposals for compulsory health warnings on all cigarette packages sold in the Soviet Union have been backed by one Moscow ministry and promptly blocked by two others, according to the weekly journal *Literaturnaya Gazeta*.

The newspaper exposes an embarrassing conflict of interests between Soviet officials promoting public health and those concerned with state commerce, reminiscent of similar confrontations between opposing interest groups in the West.

The recommendations for health warnings have been promoted by the Soviet Ministry of Health, and resisted by the ministries of agriculture and light industry, which supervise the production of tobacco and the manufacture of cigarettes.

Health authorities in Russia are alarmed by the rising number of smokers, particularly among children aged between 13 and 15 years. A recent survey conducted by the Central Institute of Health Education, quoted by *Literaturnaya Gazeta*, estimated more than 60% of men, and 10% of women in the country were regular smokers.

Overall tobacco consumption is rising, despite a variety of government measures intended to discourage smoking, and the proportion of women among smokers is believed to be also on the increase. This tends to confirm the conclusions of a fresh statistical survey issued by the United Nations' World Health Organization here, attributing an international trend of increasing lung cancer deaths among women to their changing attitudes to smoking.

The Soviet Union is the world's fourth largest producer of tobacco (after the United States, China, and India); but last year the country had to import large quantities of raw tobacco, as well as cigarettes from eastern Europe.

Regulations forbidding smoking in schools have been issued recently by the Soviet Ministry of Education. It has introduced also compulsory courses about the health aspects of smoking in all universities and institutes of adult education. The State Sports Committee has banned the sale of cigarettes at sports grounds, and prohibited smoking at swimming pools and covered stadiums.

Smoking is forbidden also in many restaurants and cafeterias, theatres, cinemas, and all means of public transport including aircraft on domestic flights of less than four hours. The Ministry of Health has instructed all medical staff to refrain from smoking in the company of patients and students.

Its controversy over proposals for health warnings on cigarette packages has been exposed in *Literaturnaya Gazeta's* own journalistic campaign for more drastic measures to combat the rise of smoking in the country. The newspaper said the recommendations have met bureaucratic obstacles placed by interests in officialdom representing the tobacco industry.

The problem reflects a vicious circle of central planning. The ministries of agriculture and light industry, as well as trade officials in Moscow, are reluctant to discourage public demand for tobacco products because they are under obligation to increase production, and sales, by 16% in the Five Year Plan to 1980. The increase had been planned, accurately, to satisfy a rising consumer demand; and the Soviet tobacco executives, like their Western opposite numbers, are more concerned with their production targets than with health.

NZ moves to seal off drug traffickers

By Tony Garnier

WELLINGTON — The New Zealand government has embarked on a campaign to seal the country off from the world's drug traffickers.

Although New Zealand is in the middle of a lengthy economic downturn and the government has cut expenditure to the limit, Cabinet approved recently substantial funds to try and isolate the country and eliminate the massive upsurge in heroin trafficking from South East Asia.

The measures include the purchase of two customs launches, X-ray machines, and radio equipment, and the provision for the introduction of improved body-search techniques. The customs department has also recently been given approval to recruit 41 additional officers, mainly for drug detection work, and a plan is underway to boost the dog squad from five to 21. On the police side, both Prime Minister Rob Muldoon, and Minister of Police, Allan McCready, have recently visited South East Asian countries to explore prospects of New Zealand's stationing officers in Thailand to help with international police liaison work.

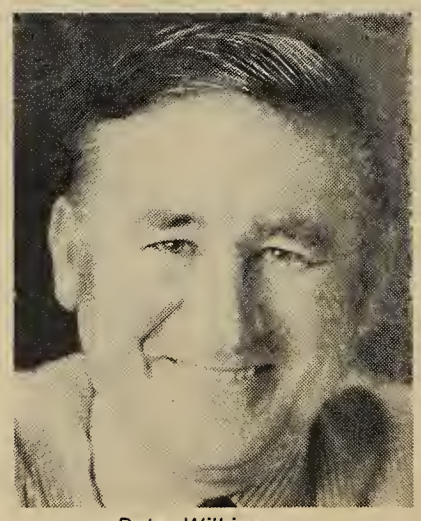
The reasons for the government's increased attention to curbing drug trafficking are not difficult to find.

In the five years between 1972 and 1977, the customs department haul of heroin has jumped from none to more than 1,500 grams. The police entered six prosecutions involving heroin in 1973. In 1977, the number had risen to more than 150.

The statistics alone have appalled many New Zealanders. But perhaps more effective in moving the government to act has been the effect of heroin users themselves on the fabric of New Zealand society.

New Zealand is a small country (3.1 million people) where "everyone knows everyone." Even the Minister of Customs, Peter Wilkinson, has been deeply affected at first hand, making him resolute in his determination to "eradicate" the drug from the New Zealand scene.

About 18 months ago, he was invited to a Wellington flat to talk with a heroin addict. To his continuing horror, Mr Wilkinson found a young man — now dead — in an advanced state of addiction. Apparently aware that his life was wasting away, the young man pleaded with the then new customs minister to stop the heroin traffic.



Peter Wilkinson

"It brought the drug problem home to me in a personal way. You would have to be completely heartless not be be moved."

Another reason for the government concern is evidence that some of the illicit drugs entering New Zealand are the work of what Mr Wilkinson termed "a hard-core organization."

Recent Court cases suggest a drug syndicate at work whose methods include recruiting women with no criminal records and sending them to a South East Asian country on all-expenses paid holidays. The women are supposed to come back to New Zealand with quantities of heroin secreted inside their bodies.

Among the tasks of the two drives will be intercepting a recent upsurge of drug "drops" from overseas freighters and yachts as they arrive at the New Zealand coast. In the last 18 months, police and customs staff have intercepted massive hauls of cannabis and heroin in Auckland and Tauranga harbors in the north of the country.

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AUDIO CASSETTE PRESENTATIONS

AT-013 CHANGING THE DRUG DEPENDENT LIFESTYLE

21 minutes *by Anne McKay*

Lifestyle change is a difficult challenge facing alcohol and drug abusers. Anne McKay, formerly an occupational therapist with the Addiction Research Foundation of Ontario, discusses leisure related problems, leisure counseling, and the basics of a leisure service. Program planners, counselors, occupational therapists, and recreationists should find this information useful, not only in assisting alcohol and drug abusers but also in developing preventative mental health, pre-retirement, community re-entry, and other lifestyle change programs.

AT-014 SOLVENT AND AEROSOL ABUSE

25 minutes *by Alec Gabe, Frederick Glaser, and Adrian Wilkinson*

What are solvents and aerosols? Who abuses them and why? What can the community do about it? These questions and others are explored in a wide-ranging discussion including Mr. Alec Gabe, information counselor; Dr. Frederick Glaser, head of psychiatry; and Dr. Adrian Wilkinson, clinical psychologist; all with the Addiction Research Foundation of Ontario. Approaches to the management and control are presented along with a discussion of the evaluative process.

AT-015 DRINKING-DRIVING COUNTERMEASURE PROGRAMS

24 minutes *by Pamela Ennis*

The focus in this presentation by Dr. Pamela Ennis, a scientist with the Addiction Research Foundation of Ontario, is on drinking-driving countermeasure programs. Strategies of primary, secondary, and tertiary intervention are considered and their effectiveness is discussed in the context of general and specific deterrence.

OTHER CURRENT TITLES

AT-001 PREGNANCY AND DRUGS — *by Barbara Tucker*

AT-002 FAMILY THERAPY — *by Reesa Kassirer*

AT-003 WOMEN AND PSYCHOTROPIC DRUGS — *by Ruth Cooperstock*

AT-004 COUNSELLING THE CHILDREN OF ALCOHOLICS — *by Kathleen Michael*

AT-005 DETOX CENTRES — THE ALTERNATIVE — *by Dianne Hobbs*

AT-006 COCAINE — *by Oriana J. Kalant*

AT-007 CONTROLLED DRINKING CONTROVERSY — *by Norman Giesbrecht*

AT-008 THE WOMAN AND HAZARDOUS DRINKING — *edited by Deborah Levine*

AT-009 TEENAGE DRINKING: USE AND ABUSE OF ALCOHOL — *by Reginald G. Smart*

AT-010 EMPLOYEE ASSISTANCE PROGRAMS: An Overview for Employers — *by Bryan White*

AT-011 OUTPATIENT TREATMENT OF THE ADULT ALCOHOLIC — *by Michael Jacobs*

AT-012 DRUGS AND THE TEENAGER — *by Dana L. Farnsworth and Michael Jacobs*



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French marijuana laws under attack



Valery Giscard D'Estaing

By Lynn Payer

PARIS — A special task force on drugs, appointed in June, 1977, by French President Valery Giscard D'Estaing, has recommended occasional users of small quantitites of hashish not be sentenced to prison.

"This is already the case in France's large urban areas, and we are recommending that it be extended, experimentally, to the entire country," said Monique Pelletier, who headed the task force.

She emphasized, however, this did not mean they were recommending decriminalization.

"There are two main reasons we did not recommend decriminalization," she said at a press conference following the presentation of the report to the French President.

"One is, there still seems to be a lot of scientific uncertainty concerning the effects of hashish. The other is that the use of such drugs, for many young people, is already the symptom of something, and as such is not neutral."

She also emphasized the task force rejected the distinction between "hard" and "soft" drugs, noting there are 60 different varieties of cannabis of varying strengths. Rather, they preferred to distinguish among varying types of drug behavior, ranging from the occasional smoking of marijuana to heroin addiction.

Mrs Pelletier, who was appointed January 10 to the position of Secretary of State in the Ministry of Justice, and is called Madame Drogue by *Le Monde* emphasized the use of illicit drugs in France does not constitute the social problem alcohol use does.

"As far as one can sketch the social consequences of drug addiction, whatever the dramatic character of its individual and familial consequences, it does not seem to be the social plague that alcoholism is.

"The intensity of the 'drug problem' has not become what was feared several years ago. Whatever the passionate reactions, the 'tolerance threshold' of drug addiction has not been reached."

This is particularly true of heroin useage, she said. However, there has been a recent increase in the use of cocaine, amphetamines, hallucinogens, and inhalents. There has been also an important increase in alcoholic intoxication in young people, particulary rural youths, and a "spectacular increase" in the misuse of psychoptropic medications.

The task force made additional recommendations, which, it said, were designed not so much to influence the individual drug user, but to create a climate unfavorable to drugs:

- Centres for young people, similar to the JAC centres in Holland, should be created. While a major effort should be made to inform young people about drugs, such information should not be isolated from other subjects, such as sex and problems of adolescence, and it should not take the form of drug lectures. Rather, adults competent to respond to questions that adolescents might ask, must be available.
- The French contribution to the United Nations Fund for Drug Abuse Control ought to be doubled; and an effort made to cooperate with other "consumer" countries in dealing with "producing" countries. Mrs Pelletier said nearly all drugs in France come from abroad. Most heroin comes through Amsterdam, although recently a direct Bangkok — Paris connection has been working.
- Repressive actions against traffic must be better adapted to the form that traffic is taking.

"The time of large laboratories, powerful organizations, and the 'French Connection,' is over, at least for the present," according to the task force.

Rather, it said, trafficking is done by small dealers and small groups that are constantly forming and breaking up.

- A greater effort should be made to prevent psychotropic medicines from finding their way into drug abuse circles, possibly by changing certain prescription regulations.
- There should be better coordination among the governmental organizations trying to fight drug abuse. At the moment 10 different French ministries each have their own programs.

Specialist calls for five changes

PARIS — Most French specialists want an immediate change in the 1970 drug laws, according to Marmotton psychiatrist Francis Curtet.

Dr Curtet's report to the Ministry of the Interior was released recently at a conference in Lisbon, sponsored by the International Council on Alcohol and Addictions.

His report proposes establishment of "specialized" groups throughout France to harbor and support drug addicts when they emerge from prison, a regular information service for judges, and specialist training for the judges of the future.

Dr Curtet put forward five proposals for immediate changes in the law: the use of marijuana and all its products should be decriminalized; the concept of illness should override the concept of delinquency; recidivism should be regarded as an integral part of the illness; customs fines should be dropped; and, compulsory detoxification should be therapeutically defined.

He emphasized none of these recommendations could be effective in isolation.

Cigarettes not welcome at WHO

GENEVA — The United Nations' World Health Organization (WHO) has intensified its anti-smoking campaign at its headquarters here.

World Health, the monthly journal of the organization, says all meeting rooms at WHO's Geneva headquarters have been included in the non-smoking area of the building.

It explains that smoking had been prohibited for some time in the main meeting room of the building, where WHO's executive board and other bodies meet, and which is also periodically hired out to other organizations.

Resolutions seeking measures to combat smoking have been passed here by the last three World Health Assemblies. The last such resolution recognized "the indisputable scientific evidence showing that tobacco smoking is a major cause of chronic bronchitis, emphysema, and lung cancer, as well as a major risk factor for myocardial infarction, certain pregnancy-related and neonatal disorders, and a number of other serious health problems." The resolution added non-smokers involuntarily exposed to tobacco smoke, could also suffer.

Two-thirds of the space in the cafeteria of the organization has been reserved for non-smokers.

Around the World

Young workers

A quarter of young factory workers could have a drinking problem in later life, if the results of a Scottish study of 16- to 29-year-olds are correct. The study, answered by more than 100 male industrial workers, shows more people are starting to drink regularly at an earlier age. Only six people in the study group did not drink, or drank very little. In the 16 to 19 age group, 10 people had a potential problem with alcohol, and three claimed they started drinking regularly at the age of 14. The survey used four criteria to judge a person's potential for having an alcohol problem; drinking more than four days a week, drinking more than five pints of beer or 10 whiskies in one session, answering 'yes' to 25% of the questionnaire, and mixing one's drinks.

Fatal examples

Adolescents are being taught dangerous overdose drinking habits by their parents and elders, a New Zealand doctor claims. Dr Fraser McDonald of Carrington Hospital said New Zealanders don't realize how close to the danger level their so-called social drinking is. Children are being brought up seeing their parents "drinking and flaking," and are learning to accept this as normal adult behavior. "Youngsters spend their weekends overdosing with alcohol, but what they don't realize is that alcohol is a poison, and it can kill anyone, not just alcoholics," he said.

Prohibition

Morarji Desai, prime minister of India, has suggested prohibition of alcohol should be achieved within four years. The central government may compensate individual states for the loss in excise duty.

Czechs lead

The estimated number of deaths in Czechoslovakia associated with smoking, amounts to between 30,000 and 40,000 a year, according to the *American Cancer Society Journal*. In 1972, the number of cigarettes sold in the country was 27 billion, or 1,900 per capita. This places Czechoslovakia in first place in Europe in tobacco consumption, and the third in the world. In recent years, the increase in the number of Czech smokers is being attributed principally to women and adolescents — those aged 15 to 18 years have the highest risk of starting smoking.

Smoking torch

Visitors to the 1980 Olympics in Moscow will not be allowed to smoke in any sports facilities according to a ruling of The Committee of Physical Culture and Sport. Sale of tobacco products will also be prohibited at the games. The ban will apply to visitors and athletes alike, and smoking by members of the Soviet national team will be "totally unacceptable." Only the symbolic torch of the Olympiad will be lighted and allowed to 'smoke'.

A new book on alcoholism for readers of The Journal.

FOUR STEPS TO FREEDOM has recently been published by the PH Company. It is described as "a guide for the person who loves and cares for an alcoholic and wants freedom from the problem."

This 54-page book gives the 26 signs of alcoholism, explains the disease of alcoholism, defines the alcoholic, tells the reader where to get help, shows the action one can take to help someone stop drinking. **Business Week** says FOUR STEPS TO FREEDOM "... can help you to help an alcoholic."

This book can be helpful to you in work with families who have an alcoholic member. Send for a copy today. Read it. And if you don't agree that it can provide the kind of help suggested, return it for a full refund. Quantity discount prices are listed in the book so that you can order additional copies to give to those with whom you work. Write today for your copy of FOUR STEPS TO FREEDOM. Send $3.50 plus .35c postage to PH Company, Dept. XXX, Box 325, Westport, CT 06880.

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Amazonian vine is a powerful hallucinogenic

(from page 16)

days the *masato* ferments.

When the desired potency is reached, the *masato* paste is put through a sieve to remove fibres and foreign matter, and water added. Mr Jenson finds the taste "very much like good buttermilk when it is fresh, but it gets more bitter and stronger each day."

Potent *masato* is reserved for celebrations of both Christian and Yagua dates.

Every family has a jar or two of *masato* on the go. It is always available, and drunk out of a calabash by everyone, including children.

The most important ceremony of the year is the feast of the dead, on a date determined by the *shaman*. Drinking and dancing go on for three or four days.

Men take along packets of *masato* paste to dilute and drink when they go deep into the jungle to hunt for monkey and wild boar.

All Yaguas, except the *shaman*, are equals. Drunken fights are rare, and Mr Jenson has never heard of a case of infidelity.

Some Yaguas, such as the ones who work at the lodge, may join in a party with the river people, and pay for drinks. The system does not work in reverse.

Mr Jenson explains: "The river people will, unfortunately, take every advantage of the Indian. If they think they can get enough free liquor, they will go to a Yagua fiesta, because they know the Indians do not charge."

Some of the river people smoke marijuana, which is not indigenous to the area, but is now grown widely. Jute grows wild, and it is smoked frequently. Less so is the angel's trumpet vine: the dried leaves are toxic, and can be lethal.

The *shaman* is the only Yagua who controls the use of *ayahuasca*. It is confined to ceremonies to cure the ill.

The vine grows only in areas which are not flooded. It is fetched by the *shaman* who mixes it with other plants, and boils it into a foul tasting brew.

Mr Jenson has been at several curing ceremonies, and allowed to drink *ayahuasca*; "Every Yagua believes no disease is natural, and everything is caused by the malevolence of others.

A person may be ill because he has received in his body an invisible blowgun dart. The *shaman* makes a great ceremony of sucking up the poison, and spitting it out.

"The ceremony is attended by people who need curing, those who have been cured and want a little extra insurance, and close relatives of the person who is ill.

"The *shaman* determines the exact amount of *ayahuasca* each person drinks from a gourd. The ceremony is controlled by the chanting of the *shaman*, and the rattling of dried leaves.

"The *ayahuasca* produces technicolor visions, but you are aware of what is going on. The eyes are very photosensitive, so the room is dark. The ceremony ends at daybreak."

Along with technicolor visions, *ayahuasca* produces severe vomiting and diarrhea.

The most violent reaction to *qyahuasca* Mr Jenson has ever seen was in an American couple, who were both doctors, and said they had done drug research. "It was awful: the woman thought technicolor snakes were crawling all over her, and it lasted all night."

The couple stayed two extra days to recover, and Mr Jenson vowed never again to allow any visitors to become involved in an *ayahuasca* ceremoney.

Mr Jenson has found while the river people will not admit it, "w[illegible]n the going gets rough they will often come to the Indians to get cured."

One area which Mr Jenson tries to avoid is the current cocaine traffic down the Amazon to Colombia.

"Obviously there is a tremendous amount of smuggling going on, and one hears that certain towns along the river are storing posts for eventual smuggling into Colombia. That is as much as I know."

Elderly alcoholics require vigorous follow-up

By Thomas Hill

PALM BEACH GARDENS, FL — Aftercare is the most important consideration in the treatment of the elderly alcoholic, according to James McInerney, associate director of the alcohol treatment program at South Miami Hospital.

"It's comparatively easy to get them sober," Mr McInerney told a seminar here on Alcoholism and the Elderly, "but many are lost after they leave the hospital."

In general, it's necessary that anyone treating alcoholics know where they came from, and where they go after treatment.

In the program he runs at South Miami Hospital, aftercare extends over a period of two years. During the first year, the patient is seen once a week. In the second year, it's once a month.

"At South Miami Hospital we are diligent about followup," Mr McInerney added. "We've found you can't assume that the patient's problems of daily living — transportation, shopping and so forth — are taken care of."

One of the difficulties in attempting to manage and care for elderly alcoholics sometimes may be that staff trained in dealing with alcoholism aren't necessarily knowledgeable about the treatment of older people. The patterns of illness are often different in the elderly alcoholic. Alcoholism workers could learn much from gerontologists, and gerontologists could learn from alcoholism workers, he added.

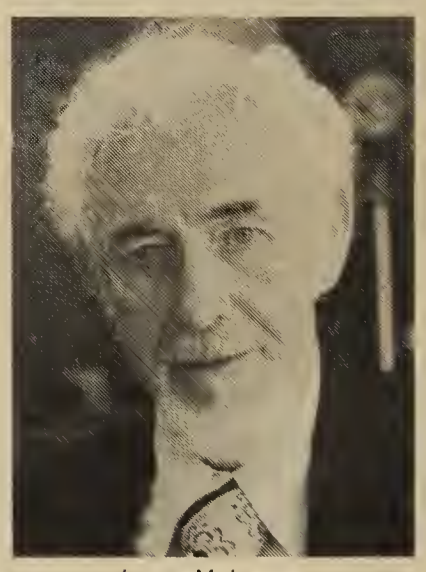
Mr McInerney said staff "may be inclined to duck the older alcoholic and the very young." In fact, there's often a tendency to write off the elderly alcoholic.

Those in charge of programs should try to find ways of making staff more comfortable with older alcoholics. Once they get into it they'll find it rewarding, he said.

Detoxification of elderly people is best carried out in a hospital setting. Their risk of complications is considerably higher than that of younger individuals.

Detoxification takes longer in older people. More time should be allowed for all phases of treatment, and Mr McInerney estimated what takes three weeks in a younger patient will often require four weeks or more, in the elderly. They don't bounce back quickly from illnesses, and in their case alcoholism is superimposed on the physical deterioration of the aging process. Some virtually have to learn to walk again after a period of hospitalization.

It's most important in the intermediate phases of treatment to get family members and "significant others" deeply involved. This isn't always easy, Mr McInerney said.



James McInerney

In his experience, if no family member or "significant other" is involved, the recovery rate is low — running anywhere from 35% down to zero.

If the family is involved, a recovery rate of 60% to 65% can be expected. If both the family and the individual's employer are involved, one can figure on an 80% recovery.

It's desirable, to make use of all available social resources outside. Also, with the older alcoholic there's the question of linkage to medical services, he said.

One of the best structures for the older alcoholic is Alcoholics Anonymous, Mr McInerney maintained, but many people don't use AA as a support system in the way they should. About one AA member in six is in the elderly category, and studies have shown older alcoholics are very well received in that organization.

Another seminar speaker who gave high marks to AA was Susan B. Anthony: "Alcoholics Anonymous is not only an excellent program for recovery from alcoholism, but it is a fine preparation for aging and dying."

Dr Anthony added the main treatment approach, following detox and residential rehabilitation, is constant attendance at AA group meetings under the leadership of a sponsor.

"While the elderly are immersing themselves in AA's 12 steps, props, philosophy, and loving atmosphere, they can be readied for the 12 steps of Aging Anonymous, which a group of us have just written, and are practicing for the aging alcoholic or non-alcoholic," she added.

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factsheet

LSD (lysergic acid diethylamide) is a semi-synthetic drug derived from lysergic acid, an alkaloid found in ergot, a fungus which grows on rye and various other grains.

LSD is most frequently classified as (1) an hallucinogen — a drug which creates distortions in perception (2) a psychedelic — a consciousness (mind) expanding drug.

Other drugs which fit into these categories are mescaline, DMT, MDA, and psilocybin. The common denominator of all of these substances is they produce psychic experiences that do not ordinarily occur without drugs. Of this group, LSD is by far the strongest and longest lasting. It is 100 times more potent than psilocybin and 4,000 times that of mescaline.

APPEARANCE

When pure and laboratory produced, LSD is a white, odorless, liquid soluble powder made up of fine crystals. However, almost all drugs may be produced in white powder form and it is difficult to tell by sight just what drug it is. Street preparations of LSD are usually not quite white because they are often mixed with other substances.

LSD may also be packaged in capsules, tablets, or liquid form. In these cases, it will appear in various sizes and colors.

Due to its high potency, very small amounts are needed to get the effects. To make it easier for handling it is often placed on larger objects, such as sugar cubes or blotting paper.

Many people who buy LSD do not know what they are really getting. They may get a substance which contains little or no drug, or an extra heavy dose, or it may contain other drugs or even potentially dangerous adulterants.

EFFECTS

The effects of any drug depend on the amount taken, the past drug experience of the user, the circumstances in which the drug is taken (the place, the feelings of the user, the other people present, whether alcohol or other drugs are taken at the same time), and the way the drug is taken.

With LSD particularly, the nature and extent of the effects experienced will also depend on the purity of the drug and psychological and emotional stability of the user. In general, the effects of LSD on any particular user are highly unpredictable.

LSD is non-toxic. It does not cause physical dependence and even after long term use there is no withdrawal reaction when use of the drug is stopped.

Tolerance (resistance to the effects of the drug) develops very quickly. This means that within a short period (for example, three or four days of use) the original dose will no longer have effect. Unlike many other drugs, the LSD user cannot get a high by increasing the dosage. (This is called tachyphylaxis — somewhat like immunization).

A person who has built up tolerance to LSD will also be unable to experience the effects of the other hallucinogens; mescaline, psilocybin, and other lysergic derivatives. This is called cross-tolerance.

Sensitivity to the drug will return after a comparable drug-free interval. For example, if a person has taken LSD everyday for one week, he would have to be free of the drug for about a week before he could take and feel any of its effects again.

LSD is usually taken orally but may be sniffed or injected. The street drug preparations usually range from 100 to 700 micrograms though 20 to 25 micrograms (ie 1/700,000,000 of an average man's body weight — 154 lb or 70 kg — will produce a reaction).

Short term effects: Generally effects are felt within an hour (if injected, even sooner) and will last from two to 12 hours. The effects of the drug do not cease all at once but taper off slowly, leaving the user with periods of feeling no effect and periods of feeling the drug working. In some cases, the effects have been known to linger several days.

Significant physical effects of LSD are almost entirely on the central and autonomic nervous system. Shortly after taking an effective dose, the user may have increased blood pressure,a rise in body temperature, dilated pupils, and a rapid heart beat. Muscular weakness, trembling, nausea, chills, numbness, loss of interest in food, and hyperventilation (breathing too deeply and rapidly) are also likely to occur. Body motor skills and coordination will be impaired. (This has been shown in tests examining driving ability under the influence of LSD).

Significant effects on perception, thought, mood, and psychological processes are also experienced. A user of LSD may feel several different emotions at the same time or swing rapidly from one mood to another. Senses of hearing and sight might be intensified or merged.

LSD diminishes an individual's capacity to differentiate the boundaries of one object from another and of the self from the environment. For some this is a pleasant sensation, but for others it may produce a panic reaction.

Sense of time may also be disturbed. Convulsions have been known to occur. Insomnia may follow even after the waning of the effects.

Depending on the severity of the reaction, short term effects may be treated by one or a combination of the following:

a) reassurance in a supportive environment;
b) administering anti-anxiety agents;
c) administering phenothiazines;
d) induction of sleep with barbiturates.

Long term effects (1) Flashbacks — spontaneous reoccurrences of the original LSD experience without having taken the drug. This may take place days, weeks, or even many months after LSD has been taken. This may cause panic and fear and/or a need for treatment. It is particularly dangerous because these flashbacks occur without warning and might take place when a person is driving or using other machinery.

(2) May trigger mental illness — prolonged serious depression and/or anxiety. Thinking, judgment, and perception may be distorted for weeks or months after a 'bad trip'.

(3) Psychological dependence may develop. This is a state in which taking the drug is so central to a person's thoughts, emotions, and activities that it is hard for him to stop.

(4) Although in humans there are no known deaths directly attributable to LSD, there have been cases of suicide, both attempted and realized.

Some researchers have reported that there is a link between LSD and brain damage, chromosome and birth defects, and circulation problems. As of this date, these reports have not been proven.

PATTERNS OF USAGE AND USERS

Accumulating evidence indicates a declining use of LSD. For example, recent Canadian studies show that the percentage of students who reported using LSD in the six months previous to the survey had dropped from 6.4% in 1972 to 4.1% in 1974, a significant difference. In addition, it appears the frequency of use has also dropped.

In general, the usual pattern for LSD users is highly charged, infrequent isolated experiences. The person consumes the drug on an intermittent basis, with weeks or months of abstaining from it in between. Perhaps this is due to the rapid build-up of tolerance or because it takes some time to either assimilate or get over the effects of a 'trip' and get back into normal daily activities. During periods free of LSD, it is not unusual for the users to take marijuana or other drugs.

Users of LSD report a wide range of reasons for their involvement with the drug. Some speak of the desire to experience something more intense and more 'beautiful' than the ordinary. Others believe it gives them greater psychological insight into their personalities and is therefore helpful in solving emotional and intellectual problems. Expanding consciousness, special mystical or religious experiences, a sense of increased creativity, and the search for new kicks are also cited.

LSD AND THE LAW

LSD is in the restricted drug category, Schedule H, under the Food and Drug Act. This means it is illegal for anyone to have any involvement with the drug unless special permission is granted through the appropriate governmental sources. Such permission is only granted to hospitals and research institutions for the purposes of clinical and experimental investigation and even this is strictly controlled.

Trafficking (selling or giving drug to another person) or possession for the purposes of trafficking are criminal offences punishable by fine and imprisonment. 1975 Alcoholism and Drug Addiction Research Foundation.

The Journal

This page is presented as a service to our readers. The text of the above is available in a smaller format, and can be obtained for minimal cost from. The Marketing Department, Addiction Research Foundation of Ontario, 33 Russell Street, Toronto, Ontario, Canada, M5S 2S1.

Clip this page

New Books

by RON HALL

Alcoholism: Development, Consequences, and Interventions

. . . edited by Nada J. Estes and M. Edith Heinemann

This book has been prepared for all people concerned with the care of those who have alcohol-related problems, and it is expected that the contents will contribute to the theoretical knowledge of alcoholism workers so the needs of people with alcohol-related problems may be met with greater understanding. The 29 contributors represent a variety of disciplines and address a broad spectrum of topics ranging from the epidemiology of alcoholism to psychodrama in the treatment of alcoholism. Part I deals with developmental prespectives of alcoholism, including such topics as etiological and epidemiological aspects of alcoholism, and criteria for its diagnosis. In Part II, the consequences of excessive alcohol use and alcoholism are presented, with emphasis on the effects of alcohol on various body systems. The consequences of alcohol use are further addressed in Part III, with a focus on alcohol problems in special groups such as teenagers, women, and American Indians. Finally, Part IV provides a view of an array of interventions used in various stages of illness and for family members.

(The C.V. Mosby Company, 11830 Westline Industrial Drive, St Louis, Missouri, 63141. 1977. 344p).

Other Books

Alcohol And Alcoholism — Rix, Keith J.B. Eden Press, Montreal, 1977. Metabolism, physiological functions, selection by animals, drinking, recognition of alcoholism, treatment, problems in the community, references, index. 251p. $40.

Toward A Heroin Problem Index — An Analytical Model For Drug Abuse Indicators — Person, Philip H., Jr, Retka, Robert L., and Woodward, J. Arthur. US Government Printing Office, Washington, 1977. Figures, tables. 33p. 85 cents.

Alcoholic Beverages — Rose, A.H. (ed). Academic Press, London, 1977. Economic microbiology series, vol 1. Beer, cider and perry, table wines, fruit and honey wines, sake, fortified wines, gin and vodka, rum, whisky, references, index. 760p.

The Law Relating To The Misuse Of Drugs— Lydiate, P.W. Butterworth, London, 1977. Manual on the Misuse of Drugs Act 1971, Great Britain. Controlled drinking, framework of controls, appendices, tribunals, statistics, glossary, etc. 152p. $10.30.

Guide To Intelligent Drinking — Amit, Zalman, Sutherland, E.A., and Weiner, Andrew. Fitzhenry and Whiteside, Toronto, 1977. Seven-week program of the New Clinic for behavior therapy and research in Montreal shows the problem drinker how to become a moderate, social drinker. 269p. $7.46.

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six point scale. For further information, contact Linda Chung, coordinator of the group at (416) 595-6150.

Hollywood and Vine

Subject Heading: Alcohol and alcoholism overview. Attitudes and values, treatment/rehabilitation.

Details: 25 minutes, 16 mm, color, sound.

Synopsis: Some movie and television stars in Hollywood such as Jan Clayton, Dick Van Dyke, Gary Crosby, and Dana Andrews tell how they got into, dealt with, and overcame their alcohol dependency. The film emphasizes the pleasure of living free from alcohol, and shows how individuals have found satisfaction in pursuing other interests. Norman Lear and Jackie Cooper tell how they are trying to help those with a drinking problem. New York Times writer Marilyn Beck expresses the hope that because movie stars are well-known, and often admired, they will help others by telling of their drinking problems.

General Evaluation: Very good (4.8) A highly contemporary, and interesting film with a clear message. This technically well-produced film was deemed an effective teaching aid.

Recommended Use: Likely to benefit audiences of 12 years of age and older.

Decision: Alcohol

Subject Heading: Alcohol and the family.

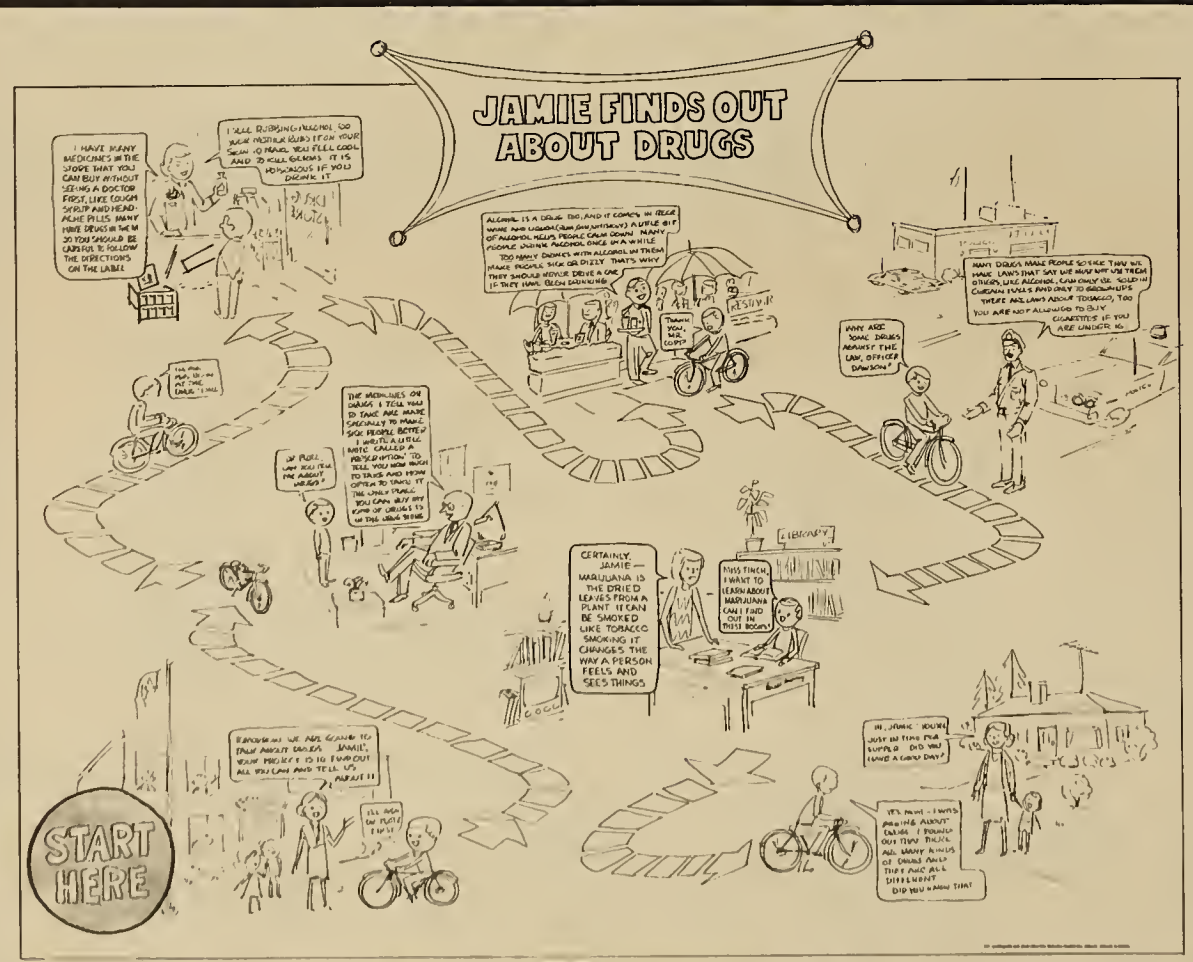
Details: 15 minutes, 16 mm, color, sound.

Synopsis: Rick lies in serious condition in hospital following an accident. He is visited by friends and family. A succession of flashbacks by each visitor reveals how each of these people was involved with Rick before the accident. In one scene, even though Rick is innocent, his parents accuse him of drinking. They embarrass him by arguing in front of his friends over his father's drinking. In another scene, Rick's girlfriend's father gives his son a beer but refuses to give one to Rick, explaining his children understand his rules about drinking. Another flashback shows Rick having an argument with a friend over drinking, and struggling within himself whether to drink. In a final scene, after a bad argument at home between his parents, Rick leaves for his girlfriend's house. On his way, he is hit by a car driven by an impaired neighbor, and ends up in the hospital.

General Evaluation: Fair to good (3.4). A contemporary and technically well-produced film. It received moderate ratings in all the other categories such as effectiveness as a teaching aid, clarity in message, informativeness, and interest level.

Recommended Use: Likely to benefit audiences of 15 years of age and older.

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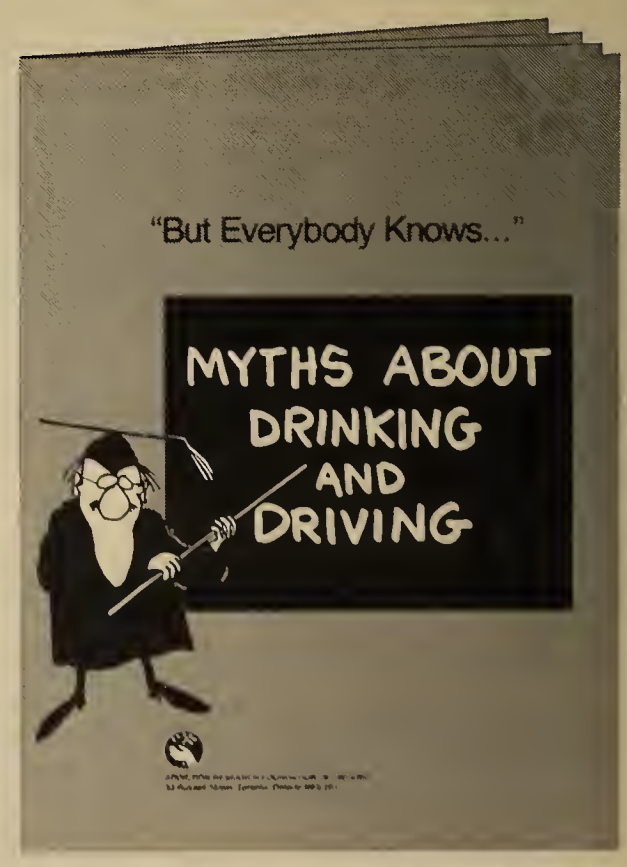
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Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada, M5S 2S1.

Canada

28th Annual Ontario Regional Conference of Alcoholics Anonymous — March 10-12, 1978, Toronto, Ontario. Information: Conference Commission, 272 Eglinton Ave W, Tor, Ont, M4R 1B2.

10th Banff International Conference On Behavior Modification — March 19-23, 1978, Banff, Alberta. Information: Donna Fraser, coordinator, Banff International Conference On Behavior Modification, 603, 733-14th Ave SW, Calgary, Alta.

Detox Workers Training Program — April 24-28, 1978, Toronto, Ontario. Information: Diane Hobbs, coordinator, Detox and Rehabilitation Programs, Addiction Research Foundation of Ontario, 33 Russell St, Tor, Ont, M5S 2S1.

Ontario Medical Association Annual Meeting — May 8-12, 1978, Toronto, Ontario. Information: Dr F.T.H. Porter, 240 St George St, Tor, Ont, M5R 2P4.

125th Annual Meeting Of The American Pharmaceutical Association — May 13-18, 1978, Montreal, Quebec. Information: APhA, 2215 Constitution Ave NW, Washington, DC, 20037.

Canadian Lung Association Annual Meeting — June 12-14, 1978, Winnipeg, Manitoba. Information: Hubert Drouin, executive secretary, Canadian Lung Association, Suite 908, 75 Albert St, Ottawa, Ontario, K1P 5E7.

Canadian Conference On Social Development — June 18-22, 1978, Vancouver, British Columbia. Information: Yolande Lachapelle, 1978 conference coordinator, The Canadian Council On Social Development, Box 3505, Station C, Ottawa, Ontario, K1Y 4G1.

Canadian Medical Association Annual Meeting — June 18-23, 1978, Winnipeg, Manitoba. Information: Helga Otto, Canadian Medical Association, Box 8650, Ottawa, Ontario, K1G 0G8.

Alberta Alcoholism and Drug Abuse Commission Summer School On Alcohol And Drugs — Sept 22-23, 1978, Kananaskis, Alta. Information: Marg Bailey, AADAC Community Extension Services, 2nd floor, 812-16th Ave SW, Calgary, Alta, T2R 0T2.

The College Of Family Physicians of Canada Annual Meeting — Sept 10-16, 1978, Charlottetown, Prince Edward Island. Information: Donald Rice, executive director, The College of Family Physicians of Canada, 4000 Leslie St, Willowdale, Ontario, M2K 2R9.

13th Annual Conference Of The Canadian Addictions Foundation — Sept 24-29, 1978, Calgary, Alberta. Information: Stuart Hutton, conference manager, Action Plan '78, 812-16th Ave SW, Calgary, Alta, T2R 0T2.

The College Of Family Physicians Of Canada (Ontario chapter) Annual Meeting — Oct 16-18, 1978, Toronto, Ont. Information: Marcia Barrett, 4000 Leslie St, Willowdale, Ont, M2K 2R9.

CanadianPsychiatricAssociation Annual Meeting — Oct 18-20, 1978, Halifax, Nova Scotia. Information: Dr A. Cote, secretary, Canadian Psychiatric Association, Suite 103, 225 Lisgar St, Ottawa, Ontario, K2P 0C6.

United States

Alcoholism And The Family Workshop — March 18, 1978, Washington, DC. Information: Dr Berman, Washington Psychological Center, 2139 Wisconsin Avenue NW, Washington, DC, 20007.

Cruising Medical Seminar On Alcoholism — March 18-29, 1978. Information: Seminars Unlimited, 1127 11th St, Suite 501, Sacramento, California, 95814.

5th National Drug Abuse Conference — April 3-8, 1978, Seattle, Washington. Information: NDAC-78, 200 Broadway, Seattle, Wash, 98122.

International Arctic Rim Conference On Alcohol Problems — April 16-20, 1978, Fairbanks, Alaska. Information: International Council on Alcohol and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

National Council On Alcoholism Annual Forum — April 27-May 3, 1978, St Louis, Missouri. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

American Medical Society on Alcoholism — April 27-May 3, 1978, St Louis, Missouri. Information: J. G. Chen See, MD, 733 3rd Ave, New York, 10017.

American Psychiatric Association Annual Meeting — May 8-12, 1978, Atlanta, Georgia. Information: Dr M Sabshin, 1700 18th St NW, Washington, DC, 20009.

The Committee On Problems Of Drug Dependence 40th Annual Scientific Meeting — June 4-6, 1978, Baltimore, Maryland. Information: Joseph V. Brady, professor of behavioral biology, The Johns Hopkins University School of Medicine, 720 Rutland Ave, Baltimore MD, 21205.

American Medical Association Annual Meeting — June 17-22, 1978, St Louis, Missouri. Information: James H. Sammons, MD, 535 N Dearborn St, Chicago Illinois, 60610.

27th Session of the University of Utah School on Alcoholism And Other Drug Dependencies — June 18-23, 1978, Salt Lake City, Utah. Information: University of Utah School On Alcoholism And Other Drug Dependencies, PO Box 2604, Salt Lake City, Utah, 84110.

Joint Conference Of The American Association For Automotive Medicine And 7th International Association For Accident And Traffic Medicine — July 10-15, 1978, Ann Arbor, Michigan. Information: AAAM executive secretary, PO Box 222, Morton Grove, Illinois, 60053.

1978 Summer Institute on Drug Dependence — Aug. 27—Sept 1, Colorado Springs, Colorado. Information: Summer Institute, PO Box 2172, Colorado Springs, Col, 80901.

Alcohol And Drug Problems Association Of North America Annual Meeting — Sept 24-28, 1978, Seattle, Washington. Information: Lynn Buttorff, executive assistant to director, ADPA, Suite 204, 1101 15th St NW, Washington, DC, 20005.

Association of Labor-Management Administrators and Consultants on Alcoholism Annual Meeting — Oct 4-6, 1978, Seattle, Washington. Information: ALMACA, 11800 Sunrise Valley Drive, Suite 410, Reston, Virginia, 22091.

Abroad

18th Australian Alcoholics Anonymous Convention — March 24-27, Canberra. Information: convention chairman, PO Box 600, Manuka ACT, 2603, Australia.

4th International Conference On Alcoholism And Drug Dependence — May 22-26, 1978, Caracas, Venezuela. Information: Merseyside, Lancashire, and Cheshire Council on Alcoholism, B15, The Temple, Dole St, Liverpool, L2 5RU, England.

8th International Institute On The Prevention And Treatment Of Drug Dependence — June 4-9, 1978, Menton, France. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

5th Institute On Drugs, Crime, And Justice In England — July 11-29, 1978, London, Eng. Information: Arnold Trebach, director, Center for the Administration of Justice, The American University, Washington, DC, 20016.

19th International Congress Of Applied Psychology — July 30-Aug 5, 1978, Munich, Federal Republic of Germany. Information: Travelaide Ltd, 4450 St Denis St, Montreal, Quebec, H2J 2L1.

32nd International Congress On Alcoholism And Drug Dependence — Sept 3-8, 1978, Warsaw, Poland. Information: ICAA Case Postale 140, 1001 Lausanne, Switzerland.

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THE AMAZON







Blowguns and curare-tipped arrows are used by Yagua men to hunt monkeys and birds (left). Masato, fermented from manioc root, is brewed by every household, and drunk from a hollowed-out calabash (right). A shirt waved from the river banks hails the collectivo water taxi. Photos: Harvey McConnell.

Alcohol dominates social and economic life

IQUITOS, PERU — Intermittent, muffled shouts and laughter mix with screech of toucan and parrot across the jungle's foliage.

Drunken farewells in Spanish and Yagua tinkle off as the Sunday sun, rising over the Amazon rain forest, signals the party's end. Adults and children tumble into hammocks or beds in their stilt-raised houses to sleep it off.

It is the same every weekend among people who live along the mighty Amazon River. A modern Hogarth could letter a sketch: "Drunk for 50 cents. Dead drunk for a dollar."

The problem of alcohol abuse in South America is immense. Some governments, like Peru's (**The Journal**, Feb), are using tax hikes and education programs as counter-measures.

Programs on alcohol problems are broadcast on the powerful 50,000 watt radio stations in Iquitos, which beam out over a vast area of the Amazon basin. There is hardly any family which does not own a portable radio.

Realization is one thing; change another.

Social pressures are powerful on men and women to drink on the weekends. Children as well: often they start at age 12 or 13.

Alcohol is part of the economic way of life. It is one inducement to get fields cleared, and many landowners, through the company store, use it to suck back the wages of their workers.

This particular party was held by people living near the mouth of the Yanamono River, an Amazon tributary 50 miles, and four hours by fast boat, downriver from Iquitos. It marked election of a local lieutenant governor, an honorary post, but an excuse good enough for a big fiesta.

It was a joint celebration of the river people and the Yagua Indians, who live quite separate lives.

The river people are *mestizo*, a blend of Indians and those who have roamed the Amazon for the past four centuries: Spanish, Portuguese, and Black. They consider themselves, and their culture, Spanish, and they look down on the Indians.

The Yagua settlement is one of many scattered along 150 miles of the river towards the border with Colombia. The last census, in 1961, showed some 6,000 Yagua still living in a tribal society.

The Yaguas have kept their language, although the children learn Spanish in school. They live in extended families, have no class system, and have adopted only a modicum of "civilized" items. The few include flashlights and metal cooking utensils.

They grow their own crops, and their favorite meat is monkey. Hunters use blowguns with curare-tipped arrows.

The Yaguas drink rum on the weekend, but their staple beverage is *masato*. Medicine is practised by the *shaman*, or witch doctor, and he controls the use of the hallucinogenic *ayahuasca*, a concoction from a jungle vine.

A number of those who celebrated this particular weekend are employees at a lodge on the Yanomono owned by Peter Jenson, an American. He came to the area 15 years ago as an anthropologist to do research. He turned businessman to stay and open the lodge.

Beer very expensive

Mr Jenson has written a monograph on the Yagua and learned their language. He employs several young guides from the settlement across the river, and allows tourists to intrude only briefly in their daily lives.

He is aware personally of the problems of alcohol. Five years ago he realized he was drinking a case and a half of beer daily, and he stopped completely.

Mr Jenson says: "Alcoholism among the people here is a really big problem, there is no doubt about it. It is a problem for us in terms of staff, who often show up unable to work.

"I would think that out of our 52 employees, we have 12 who would be considered clinical alcoholics. There are others, like our head waiter staggering around over there, whom I wouldn't call alcoholic, but who have the potential to be.

"I would say that in 90% to 95% of the river people families, at least one member is an alcoholic."

The drink of the river people is cheap, high-proof rum, or *aguadente* ("water with teeth"), distilled from sugar cane. Beer, which has to be shipped in, is very expensive.

The rum drunk in the Yanamono area is produced at the local sugar cane mill. Cane residue is fermented in large, hollowed-out tree trunks, and distilled.

Price is what makes the rum so pernicious. Despite recent tax increases, a bottle sells for 50 soles (40 cents).

Mr Jenson points out: "Almost anyone who does any kind of work at all, or even sells a bunch of bananas, can afford to buy enough rum to really lay one on for his whole family."

Any excuse will do

Most of the major land owners are descendants of those given Spanish land grants. The fields are flooded every year by the Amazon, which rises 40 to 50 feet.

But abundant tropical crops do not mean much extra money for the river people. Iquitos is the only place to sell, and it takes 14 hours to reach by the *collectivo* water taxi which is pushed along by a small 10 hp outboard motor.

Iquitos, centre of the 19th century rubber boom, and resuscitated five years ago by the search for oil, has no roads out. Links with the outside are ocean freighters, which come 2,350 miles up river, or planes to Lima, 800 miles across the Andes.

Hard drinking among the river people starts at midday Saturday and continues through Sunday night. Rum is drunk straight, or cut with water.

A birthday is a perfect excuse for a big fiesta, and for the celebrant to make money on the side.

Friends and neighbors, including children, are all invited. The evening starts with a free drink or two, and then each guest has to buy his own. The host engages a drummer to beat the rhythm for dancing. "No good fiesta will ever stop before daylight," Mr Jenson adds. Social control is strong, and there is little violence because of alcohol. Anyone who does start a fight while drunk is dealt with summarily by a local official, and has to spend 24 hours in a portable "jail" — a cage pushed under the raised porch of the offender's house.

Mr Jenson: "The cage is not big enough for you to stand up fully, nor to lay out. You have to almost hunch. Twenty-four hours in that cage, with everybody walking by and laughing, is enough that most people never get violent again when drunk."

Society is still male-dominated. If a wife is unfaithful while intoxicated, the matter is settled quietly and amicably, with the aggrieved husband receiving a certain amount of money.

A company store is usually the only local source of supplies, and is run by the local landowner. He uses alcohol to get wage money back, especially from the Indians.

Mr Jenson says the system is simple. "Money for any work done during the week is doled out individually for each day, to each person. Then they are given a couple of free drinks.

"If there is a fair amount of money involved in payments, the manager will suddenly disappear into the back and return with goods which have not been on show, such as bolts of cloth."

While the women admire the cloth the men start to buy drinks. "It goes on until almost all the wage money is back into the till."

The late owner of the area where Mr Jenson has his lodge was an exception. "He was a very nice man, and much better to the Indians than most. He would often ask our help to take sick people upriver, where a nurse could see them, and he paid for everything out of his pocket.

"He was in his late 40s when he died of alcoholism."

Masato from manioc

Almost the only way land can be cleared is by the *minga*, or work party, which turns into a roaring fiesta.

Tropical growth is so lush it is impossible for only a few hired hands to root it out. So, the minga, which involves at least 20 families, starts early in the morning. Women and children brush out as the men cut down the trees.

A limited amount of rum is doled out during the day. A huge meal, with wild boar as the centrepiece, is served at noon. The field is cleared by late afternoon, and the fiesta begins. This time, drinks are free, and an orchestra plays all night as people drink and dance.

Drinking among the Yaguas is somewhat different than among the river people. They tend to drink rum on the weekend, when they have the money to buy it, but the staple beverage is *masato*. It is made from manioc root and has been brewed for centuries.

The root is peeled, boiled until soft, put into a trough, and mashed into a rough paste. Women sit around the trough, scoop up large mouthfuls of paste, chew it vigorously, and spit it back. The chewed-up paste is put into pottery jars, covered with palm leaves, and left to ferment. Potency is determined by the number of

(See — Amazonian — page 12)

THE BACK PAGE

The Journal

Vol. 7 No. 4 | Published monthly by Addiction Research Foundation | TORONTO April 1, 1978

Quebec moves to add 8,000 new wine outlets



TORONTO — The Quebec government is going to allow wine sales in grocery stores from June this year.

The move is intended to improve wine and cider sales without increasing alcoholism in the province, according to Gilles Bourdeau, a spokesman for the ministry of industry and commerce. Mr Bourdeau told **The Journal** the addition of some 8,000 new outlets for wine won't necessarily increase alcoholism in the province. "It will just be easier for regular consumers to get it."

Meanwhile, a private group in Ontario, Alcohol and Drug Concerns Inc, has asked the provincial government here to *reduce* availability of liquor. Two proposed ways of curbing rising alcohol consumption, according to Alcohol and Drug Concerns, are to stop the further conversion of government-controlled liquor outlets into "supermarket" style self-serve stores, and to increase the price of liquor relative to disposable income.

The recommendations made by the group were based, in part, on alcohol policy recommendations made by scientists Wolfgang Schmidt and Robert Popham of the Addiction Research Foundation of Ontario.

Commenting on the Quebec move, Dr Schmidt told **The Journal**: "If the change substantially increases the accessibility of wine, the prediction would be that consumption would increase, and this would only lead to an increase in the rate of the problem."

Dr Schmidt, associate director of the research division at ARF, also noted the additive effect in alcohol use and buying practices.

(See — Wine — page 5)

US announces new cocaine strategy

By Harvey McConnell

WASHINGTON — It is only the high price of cocaine in the United States which prevents a dramatic increase in the drug's use and consequent serious health damage.

This, in turn, makes it extremely difficult for officials to make people understand the probable dangers if the drug becomes more readily available, according to Lee Dogoloff, of the Office of Drug Abuse Prevention (ODAP).

Mr Dogoloff and Peter Bourne, ODAP director, have written a statement of present US government cocaine policy. Mr Dogoloff presented it to the annual meeting here of the American Association for the Advancement of Science.

They have estimated some four million Americans used cocaine last year, there were from 100 to 150 deaths involving cocaine use, and traffickers made $3.3 billion in illicit sales.

Mr Dogoloff said domestic strategy is to assign cocaine a

(See — Cocaine — page 5)

Illicit drug sources are tenacious

By Anne MacLennan

GENEVA — The incentive provided by increasing demand for illicit drugs will consistently undercut the efforts of law enforcement agancies unless there is concerted effort nationally and around the world, says the president of the International Narcotics Control Board.

Even when traditional producing areas are brought under control, new areas of illicit supply will emerge, Paul Reuter said in a report to the fifth special session here of the United Nations Commission on Narcotic Drugs.

"The amount of drugs of all kinds in the illicit traffic has shown no sign of decreasing," he said. And this is despite increasing practical cooperation among countries both regionally and bilaterally.

"World-wide heroin seizures, for instance, reached an unprecedented level in 1976. When one source dries up, another may almost immediately assume greater importance so that the apparently rising illicit demand can continue to be met."

Professor Reuter urged that three strategies must be pursued at both national and international levels — control of the illicit traffic, eradication of illegal supply, and the checking and reducing of demand.

"Trends recently have served to emphasize it is not sufficient to attack the illicit traffic although this must continue to be done ... Nor is it enough to provide even more resources for the eradication of illicit supply, although this too will be necessary for many years to come.

"It is not enough either, although this is assuming greater importance, to pursue research into the true causes of illicit

(See — 1977 — page 5)

Pot hot pre-election issue



Joe Clark



Pierre Trudeau

By Bryne Carruthers

OTTAWA — "Pot" has become a hot political issue once again as the expected summer federal election approaches.

The Conservatives were first off the mark with a commitment to a quick reform of marijuana laws in Canada, essentially removing the criminal aspects of simple possession of marijuana while retaining stiff penalties for trafficking.

However, until a surprise announcement by Prime Minister Pierre Trudeau, the Liberal government showed strong signs

(See — Stalled — page 5)

Comment: *Politics and alcohol*
By John Shaughnessy
Page 6

In Perspective: *Cocaine*
By Oriana Kalant
Page 10

Also...

- Wayne Howell..... 2
- Letters to Editor 6
- New Books..... 14
- Projections 14
- Coming Events..... 15

Canadian to head international strategy study

By Anne MacLennan

GENEVA — Canada's Donald Smith has been appointed to head up a study which could become the operational blueprint for international action in the drug abuse field.

Dr Smith was given the task here at the fifth special session of the United Nations Commission on Narcotic Drugs. The commission was acting on a resolution from the United Nations General Assembly (**The Journal**, March) in New York. It was one of the first resolutions from the General Assembly that directly concerned itself with drug problems.

Dr Smith, who is senior scientist in the International Health Services Division of Canada's department of health and welfare, is first vice-chairman this year of the commission, and is likely next year to be elected chairman.

He said the project is essentially a review of the drug problem as seen by member countries of the commission; of approaches in each country to treatment, rehabilitation, and prevention; and of the kinds of needs each country sees itself as having in order to help cope with the problem.

The review will serve as the basis for intense discussion at next year's meeting of the commission.

Dr Smith said he hoped the recommendations contained in it will suggest priorities for the commission and provide it with guidelines for future directions.

The aim is "a meaningful program of international drug abuse control strategy and policies, including the possibility of integrating existing policies or envisaged development assistance programs."

Working with Dr Smith will be M. Bhrouz Shahandeh of Iran's ministry of health and welfare in Teheran, and Dr Oskar Schroder of the Federal Republic of Germany's ministry for youth, family affairs, and health, in Bonn.

The team expect to hear government submissions at the meeting in New York this month of the UN Economic and Social Council and have invited written submissions by June.

Resolutions arising from this review and approved by the commission will then go back to the General Assembly for its vote.



Donald Smith

Cocaine moving into Europe

GENEVA — Canada and the United States remain the two favorite habitats of cocaine users but cocaine traffic to Europe and through South America is increasing.

And this increased traffic may "bring about a reduction in prices, thus leading to higher consumption and to greater and more damaging use," suggests the International Narcotics Control Board.

In a report to the United Nations Commission on Narcotic Drugs, the board called for vigorous measures to be taken to counter cocaine use and traffic.

The report showed that seizures of the drug in the world illicit traffic remain at high level. In the past four years, some 7.3 tons of cocaine, compared to 6.2 tons of heroin, were seized, it said.

"Given the enormous amounts of coca leaf available in the producing countries for illicit extraction of cocaine, these seizures undoubtedly represent only a very small part of the actual volume in the traffic.

"The incidence of seizures also shows that the use of cocaine is becoming widespread.

"The situation calls for closer monitoring and further investigation."

Compulsory treatment begins Jan 1, 1979

BC wants 25% success with heroin addicts

VANCOUVER — A 25% success rate will satisfy supporters of British Columbia's upcoming program for compulsory treatment of heroin addicts.

If it reduces addiction by 25%, it will have to be rated an enormous success, says Arthur Phillips, chairman of the British Columbia Police Commission and a former mayor of Vancouver. Such a success rate "would mean 3,000 people had been given an opportunity to lead normal lives. It would mean a substantial reduction in crime and its associated costs to society."

There are an estimated 10,000 to 12,000 heroin addicts in British Columbia — about 60% of the total number in Canada. British Columbia also has the worst crime picture of any province in Canada.

Directing heroin users into treatment will benefit both users and society as a whole, Mr Phillips said in a recent *Globe and Mail* article. "It does not seem unreasonable to make such direction compulsory.

"The success rate in Japan, when compulsory treatment was introduced, has been much better than that experienced by North American programs. Many of the users appeared to quit on their own when the program was introduced. Something like this might happen in British Columbia considering the large number of users thought to be very lightly addicted."

The British Columbia program will be introduced January 1, 1979 and will cost $16 million. The plan calls for heroin users to be directed into treatment through voluntary admission; referral by a doctor; direction by a court; referral by a penal institution as a condition of parole; or direction by a police officer.

In all five cases, the first step would be referral to an evaluation centre for assessment by a five-member panel on heroin use and the need for treatment. If the panel judges a person to be "a user in need of treatment" and orders him into the treatment program, he may appeal and be represented by counsel at the appeal.

When a user is directed into treatment, the program will last for three years. Community clinics, in-patient units, therapeutic communities, and an after care program will be used to provide individualized treatment for the addiction as well as job and social skills training.

The program will be compulsory. In cases where individuals refuse to cooperate while undergoing treatment, fail to attend, or escape from treatment, they will face the possibility of imprisonment for up to a year.

Paraquat pot in San Fran

SAN FRANCISCO — Marijuana sprayed with the herbicide Paraquat has begun to be found in the Bay area and authorities here believe the problem may be larger than first suspected.

"It's a frightening situation," says David Smith, director of the Haight-Ashbury Free Medical Clinic.

Three cases of "Paraquat poisoning" among marijuana smokers have been seen at the clinic. All were men in their 20s with histories of smoking two or three joints a day. They had recently smoked marijuana which they later found to be contaminated with Paraquat.

Their chief complaint was difficulty in breathing: sputum examination showed the presence of blood. All were given chest x-rays, and told to stop smoking and return for follow-up checks.

Dr Smith believes it is not only Mexican marijuana that is contaminated but also marijuana that is said to come from Colombia but that actually comes from Venezuela which also has a pot-spraying program. Colombia, he says, does not spray with herbicides.

Meanwhile, the United States has passed to Mexico research results showing Mexican-grown marijuana smuggled across the border is contaminated with the herbicide and poses a serious health hazard to users.

Mexican authorities have indicated they would like a substitute for Paraquat but consider domestic use of marijuana a serious problem and plan to continue their eradication program.

Big fast cars, little ivory clamps worry Aku-Aku

By Wayne Howell



Aku-Aku, a tiny island in the Malay archipelago, is one of those Pacific islands that might originally have been settled by Incas according to the Norwegian anthropologist Thor Heyerdahl. But whether or not the islanders arrived on some ancient version of the Kon-Tiki is beside the point, for Aku-Aku was never really on anyone's map until a few years ago when it was discovered by INCO. Now Aku-Aku has its own copper mine, wage-earning miners, bars, roads, cars, bridges, motorcycles, and a serious alcohol problem.

It was because of problems associated with the increased use of alcohol — violent crime and violent motor vehicle accidents — that the king of Aku-Aku decided to develop a code of criminal law to deal with various types of offenders. A modest man who knew that his experience in these matters was limited, the king wisely eschewed playing the role of a modern day Hammurabi. Instead, he wrote to eminent jurists in the land of INCO.

"I invite you to transform the spirit of your enlightened laws into the letter of the law for Aku-Aku," he wrote to the distinguished men of the law. In due course they responded with a model code for Aku-Aku. But when the king received it he found it puzzling. And so he went to see his uncle who was reputed to be the wisest man in Aku-Aku.

"Uncle," said the king, "I do not understand this code at all. See here — it says that if a person willfully takes another person's life then he should be sentenced to a life in prison. Now I must say that is much more enlightened that our system whereby the murdered person's family kills the murderer or one of his family members. But it says also that if a person willfully gets so besotted with drink that he is incapable of knowing what he is doing and in that condition he takes another person's life, the penalty is a slap on the wrist. Look at the case they cite by way of example: a man in the land of INCO stabbed his wife but was completely acquited because he was so drunk he 'could not have formed a homicidal intent.' The reason for this approach I cannot comprehend for in my mind the second crime is just as heinous as the first."

"It does appear rather astounding," said the uncle, "but they must have a reason for it — they always have reasons for everything in the land of INCO. I imagine that this drinking thing must be the North American version of *amok*."

"Are you sure?"

"It has to be. Consider — how does one of our people act when he goes *amok*, when he gets *mata gelap*, or what those anthropologist fellows called 'the darkened eye'?"

"He runs madly about with a knife and attacks and maims all men and animals that get in his way; afterwards he is exhausted and cannot remember what he has done."

"And what do we Malays do with people who run *amok*?"

"We try to restrain them, but we do not punish them; why should we — the poor unfortunates have been possessed by demons or malignant spirits, everyone knows that," said the king.

"Right. And so you see it is obvious: in the land of INCO they must consider alcohol to be a demon; when it possesses a person he is no longer responsible for his actions; he is *amok*. Their laws are designed to recognize this. Once you appreciate that, then you see that their laws make perfect sense. I know I must be right — how could their law make sense otherwise?"

"You must be right uncle. But now look at their recommendations with regard to drinking and the use of motor vehicles while one is impaired to maim and kill innocent victims. Again the penalty is a slap on the wrist! Look at the case they cite by way of example: a young man in the land of INCO driving while his license was suspended drunkenly swerved into a wrong lane and snuffed out the life of a motorcyclist. He got six months, a slap on the wrist. I just cannot understand their reasoning at all," said the king. "I told you," said the uncle, "that they always have their reasons. And in this case the most likely explanation is that this driving behavior of which you speak is the North American version of what the Chinese call *sukyeong* and what we Malays call *koro*."

"Are you sure?"

"It has to be. Consider — what does a Malayan feel when he is afflicted with the *koro* sickness?"

"He feels his penis is shrinking into his abdomen and feels that if it does he will surely die."

"And what does he do?"

"He runs around madly, sometimes securing his penis with a string or the little ivory clamps the Chinese use to prevent the perceived shrinkage; he is not to be blamed for his actions, because he has *koro*."

"Right. Now I have heard that in the land of INCO powerful automobiles are sexual symbols. And so, is it not logical to assume that when North Americans doubt their potency, when they feel the *koro* sickness coming on, they get tanked-up and drive around in their powerful cars; a heavy foot on the accelerator is their version of the *koro string*. And that is why this offence is treated as it is; they recognize that this behavior is the North American equivalent of *koro* and therefore they treat it with compassion."

"Are you sure?"

"It must be so. I told you they have a reason for everything in the land of INCO. The code makes no sense at all otherwise!"

(Wayne Howell is an Ottawa physician and freelance writer.)

Anytime, anywhere

Search warrant powers broadened

By Bryne Carruthers

OTTAWA — The federal cabinet has quietly shifted the power to obtain controversial "writs of assistance" (very broad search warrants) for the Mounties on drug squads from the federal health minister to the federal justice minister.

The move has a number of important implications, not the least of which is a strong indication that the federal government has started the thaw process to lift a year-old freeze on issuance of writs of assistance to the RCMP and to customs officers.

That freeze was imposed after federal court Judge F.U. Collier complained publicly that judges had no discretion to issue writs and did so only "reluctantly."

Under the Food and Drug Act and the Narcotic Control Act, for example, the sections being amended previously had allowed the health minister to request writs of assistance for RCMP officers. Under such circumstances the court "shall" issue them.

Now, the only difference is that the justice minister will be requesting all writs of assistance, instead of two separate ministers, thereby allowing supposedly the government more centralized control over the number issued and the reasons they are issued.

The writs are controversial because they are issued to individual RCMP and customs officers.

In the case of drug offences, the writs give the named RCMP officers the power to break into a private house or private property at any time or under any circumstances if they suspect they will find illegal drugs or contraband.

A specific search warrant specifying what they're looking for and restricting the area of search and seizure is not required.

At one time last year, it seemed that the government was moving to eliminate the issuance of any new writs — or at least to restrict their use for special drug investigations only.

However, sources suggest now that concerns of other members of cabinet about the impact of smuggling on domestic industries (and therefore domestic jobs) has forced the justice department to try and work out "safeguards" for issuance of writs in the future.

The first such safeguard was the transfer of the power to request writs from the health minister (who was advised by the Bureau of Dangerous Drugs) to the justice minister.

A spokesman in the health department said the Bureau merely processed applications from the RCMP; it did not ask why writs were to be issued to individual members of drug squads, nor did it ever recommend against issuance of a writ.

Under the law, the federal government can only issue writs to the RCMP in drug cases. The RCMP can also obtain them for customs infractions.

The Mounties have currently 274 writs for use in drug cases under two parallel sections in the Narcotic Control Act and the Food and Drug Act.

During 1977, these named officers of the RCMP were responsible for more than 2,300 searches, with only 118 reported as failing to turn up anything incriminating. During 1976, there were more than 3,000 such searches, supposedly because the RCMP was combating more heroin abuse in the country than in 1977.

The rationale offered by the RCMP is they need such broad search and seizure powers provided by writs of assistance because the illicit drugs they seek are often moved quickly from place to place to avoid detection. Normal warrants, which are limited in time and place, would be difficult to use under such circumstances, especially when the police are trying to follow drugs through to a final distribution point.

However, the RCMP seem to be willing to have the laws changed to give judges more discretion in issuing writs of assistance to individual officers.

NB names new commission head ...



Everett Chalmers, who has served as minister without portfolio in New Brunswick, has been appointed to head the newly created Alcoholism and Drug Dependency Commission, a surprise move to some.

By John Carroll

FREDERICTON — The government of New Brunswick has taken an unusual course in the establishment of its Alcoholism and Drug Dependency Commission and the naming of a permanent chairman.

In a minor cabinet shuffle, Premier Richard Hatfield has recalled to the executive council Everett G. Chalmers, who had served as minister without portfolio between 1972 and 1974. Dr Chalmers had chaired a study on alcoholism and written the report which led the Legislature to enact the Treatment of Intoxicated Persons Act in May, 1974.

In announcing that Dr Chalmers, a veteran of the Legislature, would become minister without portfolio, Premier Hatfield said he would have responsibility for the Alcoholism and Drug Dependency Commission. The premier referred to Dr Chalmers' chairmanship of the study several years ago and said the Fredericton West MLA was "uniquely qualified to discharge his new responsibilities."

The premier said Dr Chalmers would serve in the cabinet until the new permanent commission had been established, and then would resign to become its first permanent chairman. This would mean Dr Chalmers would also resign his Legislature seat.

The move is not without its critics. Some observers of the New Brunswick political scene see the step as one designed to open up Dr Chalmers' seat to a new candidate who could bear the Progressive Conservative standard in the provincial election generally expected this year.

In addition, there may be some wariness on the part of the province's French-speaking Acadians. A French-language reporter attending the premier's news conference questioned, in light of Dr Chalmers' views on bilingualism and the Official Languages Act, whether the new Commission would be able to serve Francophones.

Premier Hatfield said Dr Chalmers had supported the provincial Official Languages Act during its passage through the NB House and has support across the province because of his known interest in the problems arising from drug and alcohol abuse.

When the Treatment of Intoxicated Persons Act passed through the Legislature in the spring of 1974, there was outspoken opposition to the measure on the grounds that it violates human liberty and civil rights.

Then-leader of the Liberal Opposition Robert Higgins allowed his supporters a free vote on the bill. The measure was carried 30 to 15.

In the nearly four years that have elapsed, during which an interim commission functioned, the framework for the treatment of alcoholics has been steadily set in place.

A chain of detoxication and observation centres has been created, with centres located in Saint John, Newcastle, Bathurst, Campbellton, Edmunston, Fredericton, and Moncton.

An amendment to the act probably will come before the session of the Legislature which opened March 14. Last summer Health Minister Brenda Robertson said the act provides for a chairman, a commission member for each of five health districts, and four members from the general public. Since the enactment of the legislation, a sixth health district has been created.

...Critics are shocked at the shuffle

FREDERICTON — The position of executive director of the alcoholism program of the New Brunswick department of health has apparently been eliminated with the appointment of Everett Chalmers to cabinet minister without portfolio with eventual responsibility for the new Alcoholism and Drug Dependency Commission.

Arthur Young recently confirmed he had been informed of the decision to eliminate his position by assistant deputy minister of health Dr H. W. Wylie.

Mr Young said he had been told that with the appointments of Dr Chalmers and of his executive assistant Ed Thomas, there would be no need for his (Mr Young's) position.

"It was unexpected in one sense, but I thought something like this would happen. I think the fact Mr Thomas is Dr Chalmers' assistant is the reason my position is being phased out. There is no justifiable reason to have a minister, an executive assistant, and an executive director."

Mr Young said he had been brought from Ontario a few years ago "with the understanding I would be executive director of the commission once it was established."

Meanwhile, Dr Chalmers said he didn't know what the future held for Mr Young: "I have no idea about him. He's employed by the health department as far as I know."

The sidelining of Mr Young has triggered a shocked response from two of the regional coordinators of the province's alcoholism program.

Glen Murray of St John said: "I will seriously have to reconsider my position on the program, and I guess what we're talking about here is resignation.

"I was most upset at the decision. The program that Mr Young has established over the past three-and-a-half years is a good program, solidly based, and it's doing a good job. There is no professional reason why he was asked to leave. He's a damn sight better at the job than any others that have taken it," Mr Murray said.

Before Mr Young took over, Mr Thomas was acting head of the alcoholism program.

In Moncton, regional coordinator Wayne Weagle said Mr Young had done a "fantastic" job of getting a province-wide detoxication, prevention, and rehabilitation program on its feet.

'I am deeply disturbed by this move — it seems to be threatening the stability Mr Young has created."



Arthur Young

Illicit psychotropics world danger

GENEVA — The world community should be prepared to take more determined practical efforts against the illicit manufacture and potential increase in abuse of psychotropic drugs, according to the International Narcotics Control Board.

In a report here to the United Nations Commission on Narcotic Drugs, Paul Reuter noted there are two significant trends in abuse of, and traffic in, psychotropic substances.

The first is the diversion of some substances from licit sources into the illicit market. Between 1976 and 1977, the majority of barbiturates in illicit traffic continued to be diverted from licit sources.

The board urged that the policy in some countries of voluntary restriction on barbiturate prescription should continue to be actively explored.

The second, and more alarming trend, however, according to Professor Reuter, is the increasing illegal manufacture of amphetamines, phencyclidine, methaqualone, and sometimes hallucinogens, in many parts of the world, and the resulting increase in illicit traffic.

"It is true the available data in some countries indicate the amount of abuse of psychotropic substances appears relatively stable; in others, by contrast, a marked increase has been noted.

"This latter trend . . . is a particular source of concern," said Professor Reuter.

UK brewers bemoan image

LONDON — Britain's major brewers appear to be growing increasingly uneasy about the attention being given nationally to the problems of alcohol abuse.

This is shown by an appeal from one of the brewing giants, Whitbread, for more research into the social causes of the problems.

Says the current issue of *Whitbread Way*, the company's quarterly magazine: "Recent publicity has produced extreme reactions to a problem about which too little is known."

Whitbread Way is at pains to point out that there is "no parallel" between alcohol and tobacco abuse since with the latter the problem is the product. Drinking, on the other hand, "is enjoyed in perfect safety by most people."

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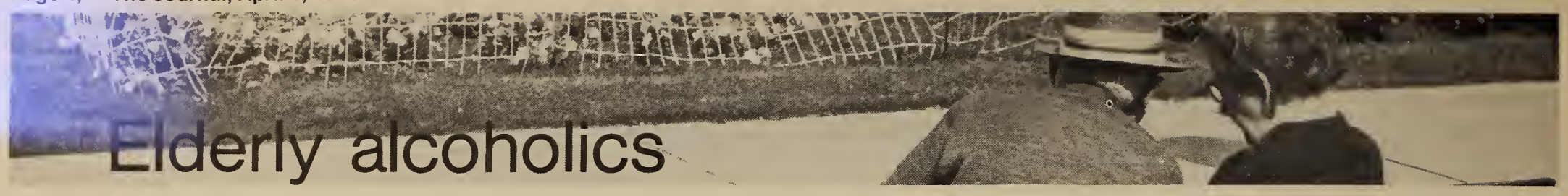
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Elderly alcoholics

Alcoholism's often lurking behind mask of age

By Karin Pargas

TORONTO — A decrease in alcohol-related problems, and not total abstinence, should be seen as a definition of improvement in the elderly alcoholic.

Increased self-worth, the ability to relate to other people, and a cut-back in alcohol consumption by the older alcoholic are important bench-marks, according to Sarah Saunders of the Addiction Research Foundation of Ontario.

Dr Saunders said here at a symposium on Alcoholism and the Elderly, that few older alcoholics enter traditional treatment programs which are geared generally towards total abstinence among the young and middle-aged population.

"Traditional alcohol treatment programs will not accept people unless they have a desire to stop and recognize their problem, and they require total abstinence. That eliminates nine/tenths of the elderly alcoholics right there," she said.

Families and friends of the elderly alcoholic are likely to hide the disease because of "shame and guilt: there's often a great desire to help them, but to help them in splendid isolation because they don't want the rest of the world to know."

Dr Saunders also said it is difficult to identify the elderly alcoholic because the majority "are terribly well-hidden in our society."

She said a person in the 70s age group, for example, who is showing signs of confusion, not eating well, and exhibiting other classic symptoms of aging, might also be an alcoholic.

"In actual fact, we find time and time again (symptoms of aging) are actually symptoms of alcoholism."

Dr Saunders said there is a great need for individualization of care and treatment planning for the elderly alcoholic. When the elderly alcoholic develops a sense of trust with his "helper," then it is possible to begin changing that person's lifestyle so alcohol is not the only pleasure he or she receives out of life.

"After the trust has been developed, it is possible to place restrictions on the drinking . . . and if the person is involved in an activity of significant interest, then they will generally stop drinking at least for the duration of that interest, or they will cut it down to a point that is acceptable to those around them."

Some elderly alcoholics have been chronic drinkers for years, Dr Saunders said, but others are those who have begun to drink because of an inability to cope with problems associated with aging — loss of job through retirement; loss of family and friends; medical, spiritual, and social problems; and difficulties adjusting to new living arrangements such as homes for the aged.

The problems of aging must all be dealt with in connection with the elderly person's alcohol problem, Dr Saunders said. "Discuss alcohol-related problems (with them), don't ignore them, but discuss them in the context of something not to be condemned, but as one of the many problems that person has. After a while, if the person trusts you, the problems related to alcohol will come out more and more into the open."

Dr Saunders said that in the next 25 or 30 years, the number of people who reach the age of 60 and older will increase dramatically, therefore "we have every right to be seriously concerned about the problem as it exists now."

Shamattawa people on recovery road

By Manfred Jager

WINNIPEG — There is striking evidence of change in the remote northern community of Shamattawa, 500 miles northwest of Winnipeg, and known for heavy drinking and gasoline sniffing among its residents.

In the summer of 1976, Shamattawa made headlines all across Canada when more than 60 of its children and young people, suffering from the effects of gasoline sniffing, were flown to the Health Sciences Centre here for treatment.

One of the patients, 15-year-old Leonard Miles, son of Chief Judah Miles, died.

Since then, the federal health and social services, the Indian affairs department, the Non-Medical Use of Drugs Directorate, and the Alcoholism Foundation of Manitoba have made concentrated efforts to improve the situation.

The Shamattawa Indian Band council set up a patrol which tours the community from noon to midnight daily, watching for sniffers. Children, and in some cases adults, found sniffing, are promptly checked by health nurses in the community. When necessary, they are sent to Winnipeg for treatment.

Numerous recreation programs have been tried and several attempts were made at setting up a drop-in centre.

Despite these efforts, incidents of gasoline sniffing and drinking remained high. In April, 1976, community patrol workers caught more than 70 children sniffing. The count stayed at a critical level throughout the summer. In October there were 42 incidents.

Then, in November, patrol leader Alex Redhead says, the number dropped to 14 and to zero in December. In January, the count was two adults and four children. So far there have been 11 cases which came to the attention of health workers for February. But the figure includes five children who were caught twice during the month, Mr Redhead says.

He says their parents have gone back to drinking.

The patrol leaders say that at one point the number of drinkers in Shamattawa included almost everybody — now it's down to about 10.

Mr Redhead and community constable Robinson Napaokesik say the reason for the dramatic drop is the strong action taken by Chief Miles and the band council with the support of most local residents.

This action began in early November at a band meeting where two band councillors were removed from office because of their drinking.

Band councillor Silas Miles said: "We simply told the people they had to settle down, stop drinking, and care for their children." The councillor feels child neglect caused by parents' drinking is the reason for sniffing.

The council backed its words with tough bylaws. People found drinking or drunk from alcohol or "bean juice," a local product brewed from potatoes and raisins, are fined $35 for the first offence. Fines increase to $50 for the second, and to $75 for the third offence. Offenders on welfare have their welfare money cut in half for a month. Four-time offenders are cut off completely for a 30-day period. Proceeds from the fines are used by the band council for various community projects.

"When people get their rations cut they soon come around," Mr Miles says.

Young people caught sniffing are taken to the community constable by the patrol workers. The chief, councillors, and parents are informed. Sometimes they are kept at the police headquarters for brief periods. In some cases, with the parents' permission, an "old-fashioned" spanking is administered.

Two grade three students say they have sworn off sniffing at least partly because of the spanking.

School teachers say class attendance is up more than 65% to 70% compared with last year. They say the students have much more energy and interest in school as the effects of sniffing wear off.

Adults found under the influence of too much drink have to answer for their misdemeanor before the council and sometimes at community meetings.

Last month, the new $150,000 Leonard Miles Memorial Drop-In Centre was officially opened.

Official response to community efforts to control drinking and gasoline sniffing has been favorable. Lyle Black, director-general of program management with the health and social service department in Ottawa said: "There is no question: a very great change has taken place here, in the people themselves."

Chief Miles, his councillors and many people in Shamattawa are well aware they are engaged in a battle that will take months, maybe years to win. And beyond the social needs there are some tough economic problems that will have to be solved.

"The point is that Shamattawa is healthier today than it was," one community leader said. "The point is that the people around here know they have to face up to their problems and work at solutions."

Help, not pills for over 65s

OTTAWA — Elderly patients need more counselling from health professionals about drug use.

Men and women beyond 65 years of age are taking more drugs and getting less guidance about their use than ever before, according to speakers at a symposium here on self care, sponsored by the Proprietary Association of Canada.

In a survey of users of non-prescription preparations at Sunnybrook Hospital, Toronto, 80% of the 50 people interviewed had practised self-medication in the previous year, and fewer than 2% of the 119 products used were recommended by a pharmacist in the pharmacy where they were purchased.

"Elderly patients are not well informed about the non-prescription drugs they are taking," said Karen Anne Adamson in her report of the survey. "But the pharmacist has a great opportunity to influence a purchase, since 90% of the non-prescription products were found to have been purchased in a pharmacy."

Heather Clarke, assistant professor of nursing at Victoria University, said this type of influence is still rare.

A 1976 study on the elderly and drug education in British Columbia found that gaps in communication between pharmacists, doctors, and their patients, along with improper methods of self-administration, were significant factors in drug misuse.

According to Miss Clarke, health professionals showed little interest in counselling seniors about their drug use. "In fact, the problem of limited time expressed by many of the pharmacists, indicated that even verbal instructions accompanying prescription dispensing is rare."

"Lack of practical information or instruction on appropriate use often leads to unwise actions including overdosage, omission, duplication, and inappropriate use of 'as required' prescriptions."

Herbicide war on drug plants

Ecological hazards demand attention

By Harvey McConnell

WASHINGTON — Mexican use of herbicides to destroy opium poppy and marijuana plants should be stopped because of the potential ecological hazards, believes entomologist Donald Dahlsten.

There is such a paucity of knowledge, "I think it is really a travesty just to go and use these things with the potential consequences for the people living there," said Dr Dahlsten, professor of entomology at the University of California, Berkeley.

He has had no direct experience in Mexico, but has studied the effect of herbicide use in areas in the United States similar to those in Mexico where drug crops are grown.

Most of the Mexican fields average a quarter of an acre, and are sprayed by light aircraft or helicopters. Herbicides used are 2-4-D, a selective preparation, and paraquat.

Application is critical, and spraying such a small area "is entirely different from spraying 2,000 acres of brush, which is different from spraying 630 acres of cotton in a controlled manner."

Studies of aerial drift have shown some 60% to 75% of the material does not arrive on the target plant.

Dr Dahlsten said his experience with forest spraying "found the drift hitting one, two, three, or even five, miles away from the target."

Studies have shown herbicides lead to "simplification of the plant community; setting the community back to an unstable condition in which some ecological niches are vacant, and altering or reducing plant competition within the treated area."

Herbicide use in mountainous areas of New Mexico and Southern California has produced a simplified plant community which is less resistant to pest outbreaks, drought, and erosion and which has a less efficient conversion of soil nutriments.

He added: "By introducing herbicides into the situation in Mexico, you are setting a stage which may mean there has to be other support technology as well. Some people do not think this is such a bad idea.

"But if this is what we are passing on to the people in terms of management of these treated lands in the future, it is something we should think about, particularly if we are going to pose substitution of multiple crops."

Dr Dahlsten was speaking at the annual meeting of the American Association for the Advancement of Science.

Quebec health blitz

MONTREAL — Quebec citizens will be blitzed by 2,639 messages on French television to stop smoking and eat wisely in the next four months.

In the Montreal area, this will mean 25 messages per week. There will also be 448 signs in subway cars.

The main message of the campaign will concern nutritional habits but, in addition, anti-smoking warnings will be directed at young people and pregnant women. They will be urged also to get fresh air and avoid non-prescription drugs.

The aim of the campaign, according to Dr Denis Lazure, minister of social affairs, is to produce over the next 10 years an entire generation of health-conscious non-smokers with good eating habits. It is aimed also at counteracting the media message that smoking is a pleasurable experience.

A future campaign in the planning will warn against the dangers of alcohol

Tipsy canine cure -- $45 an hour



NEW YORK — The alcoholic stood only six inches high and lived for creme de menthe.

An unusual case? Not for animal psychologist Daniel Tortora.

Dr Tortora is applying techniques used in treating humans to pet dogs and cats. His patients' owners pay $45 an hour for him to cure their Rovers' or Puffs' or Spots' of neuroses.

Dr Tortora said the chihuahua in question lapped up grasshoppers, a mix of creme de menthe and cream, until he had a real drinking problem.

The owner thought the dog was simply strange until it began stationing itself at the bar and barking incessantly for more.

The tipsy chihuahua was thoroughly dried out, and then given emetine, which causes vomiting when combined with alcohol. After a few miserable drinking bouts, the dog gave up his drinking life for good.

Narcotics distribution
Computers arrive

OTTAWA — The age of computers has come to the world of narcotics distribution — that is legal distribution by drug manufacturers to pharmacists, doctors, and hospitals.

Under recently approved amendments to the Narcotic Control Regulations, pharmaceutical companies are now authorized to fill requests for narcotics (other than methadone) received by computer terminal, as long as certain electronic safeguards are incorporated in the computer ordering system to ensure that only legitimate orders are received and filled.

The amendments follow a test on electronic narcotic drug ordering systems that was carried out in British Columbia recently and that showed the benefits of such a system should outweigh the potential problems.

In addition to the obvious benefit of convenience for large suppliers and buyers of narcotics, a computerized system offers the added advantage of electronic records which can be more easily cross-checked and verified by drug companies and federal health department inspectors.

Federal drug authorities are fighting a constant battle to ensure that narcotics manufactured or distributed in this country by drug companies stay within the licit drug network and do not become diverted to illicit drug networks.

As one way of controlling legitimate narcotics distribution, the government requires detailed records to be maintained on all purchases and sales of Schedule G drugs, including the barbiturates, the methamphetamines, and methaqualone.

For computerized narcotic ordering systems to be legal, the remote device used to place the order must contain a unique identifying code related to both the particular terminal and to the individual or institution authorized to use the terminal for ordering narcotics.

The code has to be an in integral part of the terminal device so that it can only be modifed by dismantling the device. And, the terminal must be in the position and care of an authorized pharmacist or doctor.

The manufacturer's or distributor's computer must also have special features, including the ability to detect unusual orders and automatically trigger intervention by the licenced dealer.

As a further check, the licenced narcotic distributor must receive within a specified time, a receipt signed by the individual who received the narcotics, including details on time and quantities of narcotics received.

If the receipt is not received on time, then the licenced distributor cannot provide any further narcotics based on a computer order.

Cocaine vogue whitewashes risks

(from page 1)

lower priority in federal programs because at present heroin and barbiturates cause higher morbidity and mortality.

However, the international thrust against cocaine trafficking in South America, and aid to Peru and Bolivia to help them phase out coca plant cultivation, has top priority.

As to what might happen here, Mr Dogoloff said health officials in Bolivia are seriously concerned over the damage to people who smoke cocaine paste frequently and for a long period (The Journal, Jan).

"This should serve as a warning signal to us. There may well be severe health consequences with cocaine use when there is a ready supply."

The major thrust of domestic cocaine policy is prevention and research into the effects of compulsive high dose cocaine use.

It has been decided "domestic penalties for simple possession of cocaine should not be reduced at this time.

"Unlike marijuana, cocaine possession laws have not resulted in inducing large numbers of otherwise law abiding young people into the criminal justice system."

Mr Dogoloff said: "It must be understood that the critical factor underlying this apparent lack of severe health consequences (in the US) is the high price of the drug, which reflects its relative scarcity, and restricts the general level of extent of use.

"The recent attention that cocaine has received in the media is of great concern to us, as is the advertising of the cocaine paraphernalia: the gold razor blades, the fancy coke spoons."

Amercians must not be led to believe that cocaine is a harmless drug, and must not be enticed by the aura of trendiness and luxury, he said.

However, it is difficult to convey to the American people a realistic warning about cocaine use, since there are currently few visible health consequences, and one does so at the risk of being discredited and disbelieved."

Mr Dogoloff said there has been a swift change in the past five years of government thinking about cocaine. A federal drug strategy report in 1973 reported no deaths from cocaine, and said it was almost never the sole drug of abuse.

"We estimate now, extrapolating to the entire US population, that there are about 100 to 150 deaths involving cocaine each year in the United States, and about a third of thesc do not involve use of any other drug."

Conjectures, based upon those facts that are available, are that 10% of users use daily; 10% every weekend, which constitutes three days; 10% one weekend a month; 10% two weekends a month; 30% two days a month, and 30% once every two months.

The street level purity of cocaine varies from 10% to 20%. However, Mr Dogoloff said: "It is believed that many of the heaviest cocaine users are well connected to the distribution systems, and that these people use cocaine at substantially higher levels of purity."

American international strategy "is to reduce the availability and increase the price of cocaine." It is more effective to attack drug distribution near the source, he said.

Serious problems are encountered in attempting to reduce coca cultivation in Peru and Bolivia.

Mr Dogoloff said: "Both major producing countries are poor, and coca is a principal cash crop for many of the people. Obviously, we cannot expect instant results.

"We are, however, hopeful for long term, lasting progress."

Mr Dogoloff emphasized that present American policy is not static.

It is trying to take advantage of what is known today "which is more than what we knew two or three years ago, and, hopefully, a lot less than we're going to know two or three years hence."

Stalled pot bill back in election gear

(from page 1)

of continued unwillingness to do what it promised in the way of reform almost half a decade ago.

At a weekly news conference, Mr Trudeau finally seemed to take notice of a recent vote at the national Liberal convention urging government to remove possession of marijuana from the Criminal Code.

The prime minister promised if his Liberal government is re-elected, it will move ahead with legislation to remove simple possession of marijuana from the Criminal Code.

Blaming the delays in marijuana reform on an overloaded parliamentary legislative slate, he said: "Support us and you will get it decriminalized."

In defence of a seemingly indefensible position, Mr Trudeau explained the cannabis bill, like "a lot of other good government legislation" had been held up by the slowpoke pace of parliamentary work.

He said his government favors decriminalization of simple possession and said the police forces and the courts have already been told the government does not consider simple possession to be as serious a crime as it used to be.

The obvious pre-election ploy belies the fact the Liberal government had refused stubbornly to move on the marijuana issue and reintroduce reform legislation, largely because the Liberal cabinet has long been badly split on the marijuana issue.

Despite the fact that at least two important cabinet ministers — Justice Minister Ron Basford and Solicitor General Jean-Jacques Blais — had indicated their support for the Liberal convention call for removal of simple possession of marijuana from the Criminal Code, the cabinet had been dragging its heels in the hope the issue would not surface during the coming election and reveal the cabinet's uncertainty on the issue.

However, the announcement by Conservative leader Joe Clark that a Conservative government would move quickly to accomplish what the Liberals have failed to do in five years evidently has set the fires under the prime minister.

In the wake of the Liberal convention, Justice Minister Basford and Solicitor General Blais had indicated they would transfer marijuana offences to the Food and Drug Act from the Narcotic Control Act and arrange legislative amendments so simple possession convictions would no longer carry with them a criminal record.

The Liberal convention had passed by a vote of 379 to 159, a resolution supporting removal of marijuana possession from the Criminal Code. The resolution had been strongly supported by Young Liberals but opposed by members of the party siding with Vancouver MP Simma Holt, who warned the Liberals would be perceived as the "party of pot" if the resolution passed.

Federal Health Minister Monique Begin, who has so far managed to stay away from the marijuana issue, has been awaiting the report of an interdepartmental committee before trying to obtain a cabinet position on marijuana reform.

Reform legislation was introduced by then Health Minister Marc Lalonde in the Senate several years ago, where it was amended considerably by a special senate committee, somewhat to the surprise of the government. However, the bill never made it to the House of Commons and has since not been redrafted and reintroduced.

Conservative leader Joe Clark told a Sarnia audience during a recent open-line radio program that a Progressive Conservative government would propose reform of marijuana laws, to distinquish between trafficking and marijuana possession.

He said there should not be a criminal record attached to possession of marijuana.

All the current Liberal government has managed to do is introduce an informal system of absolute and conditional discharges for first offence marijuana possession cases. While such discharges do not technically amount to a conviction, they do result in a criminal record.

However, the discharges also allow individuals to apply sooner for a pardon than would be possible in the case of a formal conviction.

The last time there was any government interest in marijuana was during the last election campaign, leaving some skeptics wondering whether in fact, anything will get done — very quickly at least — after an election, especially if the Liberals are re-elected. Both parties will face large legislative loads in the post-election session of parliament if the rapidly mounting number of election promises are to be implemented through legislation.

1977–enter mid-east heroin

(from page 1)

demand and into the human and sociological reasons for their evolution."

A disturbing new development in 1977, he said, was the appearance of "middle-Eastern" heroin, although still in small quantities, on the Western Europe illicit market. "It seems likely this heroin is made from opium produced illicitly in Afghanistan or Pakistan, though not necessarily converted into heroin in those two countries."

While there are signs of a decline on the illicit market in the availability of opiates from areas of illicit production in Burma, Thailand, and the Lao People's Democratic Republic, this appears primarily to be the result of better enforcement and interdiction rather than a decline in production, Professor Reuter said.

"In Afghanistan, despite United Nations' supported enforcement against traffickers, illicit opium production may actually be increasing. In adjacent areas of Pakistan, a possible reduction of opium supply this year seems to have been the result of weather conditions rather than any other factor. Other countries, such as the Lebanon, are now reported to be emerging as new sources."

Wine outlets for Quebec

(from page 1)

He said the question of whether the introduction of wine into grocery stores would increase the popularity of cider could only be answered on the basis of general marketing laws — wine and cider would likely interact in the same manner as other products.

"But I would expect that any cider buying that took place (as a result of the changed law) would be in addition to wine purchases and not substitutes for them," Dr Schmidt added.

Rodrique Tremblay, minister of industry and commerce in Quebec, said he hoped wine sales would increase the popularity of cider, already available in grocery stores. He has suggested the two products be placed in adjacent displays.

A question to be addressed in the Parti Quebecois' upcoming white paper on cultural development is why the province already has some 107,000 alcoholics, and why wine consumption went up 135% between 1968 and 1973. The white paper is expected to be made public this month.

EDITOR
Anne MacLennan

STAFF WRITER/PRODUCTION EDITOR
Karin Pargas

CONTRIBUTING EDITORS
Harvey McConnell (Washington)
John Shaughnessy (Toronto)

SCIENCE EDITOR
Dr Ruth Segal

The Journal

Published by Addiction Research Foundation of Ontario
33 Russell St, Toronto, (416) 595-6053

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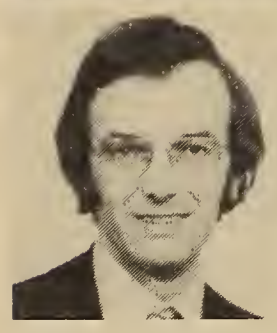
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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Comment



By John Shaughnessy

A step backward in alcohol control?

THE QUEBEC government is making a mistake in its decision to allow wine sales in grocery stores. (See page 1)

The move is intended to improve wine and cider sales *without* increasing alcoholism in the province. But evidence suggests this cannot be done.

Research at the Addiction Research Foundation of Ontario and elsewhere has shown that whenever beverage alcohol becomes more readily available because of a relaxation in control laws, levels of consumption and rates of alcohol problems tend to increase. The sale of wine in grocery stores is clearly a "relaxation." But, in a province with about 107,000 alcoholics and one where wine consumption has risen 135% between 1968 and 1973, the introduction of some 8,000 new outlets for wine should be viewed with dismay by everyone concerned with the rising personal and social costs of ill health and death attributable to alcohol.

'The Quebec government is inviting an increase in alcohol problems. . .'

Obviously, an increase in wine sales will mean an increase in consumption — whether the consumers are regular customers getting wine "easier" or new customers for wine products. If, as the evidence suggests, the larger the amount of alcohol consumed by a population as a whole, the higher will he the number of heavy consumers, the Quebec government is inviting an increase in the number of alcohol related problems among its citizens.

Further, the suggestion that the introduction of wine into grocery stores might increase the popularity of cider is suspect.

If the government is implying that increased cider sales will be at the expense of wine sales, it is probably wrong. Research on alcohol buying practices suggests wine consumers might buy cider as well as wine. But, it is highly unlikely they would buy cider instead of wine.

Whatever its effect on cider sales, the introduction of 8,000 new outlets for wine constitutes a substantial change in the availability of alcohol for Quebeckers, and will effect per capita alcohol consumption and the prevalence of alcohol-related problems.

It is interesting to speculate about whether the decision to allow wine sales from grocery stores is an unconscious move by the Separatist government to reject Anglo-Saxon ways and to promote Gallic customs — to make wine a part of everyday life as it is in France. But there are more serious issues at stake.

Unfortunately, the Quebec government's decision perpetuates the general post-war trend to liberalize alcohol control laws, and points out the inherent contradiction in the stances of most provincial governments concerning alcohol.

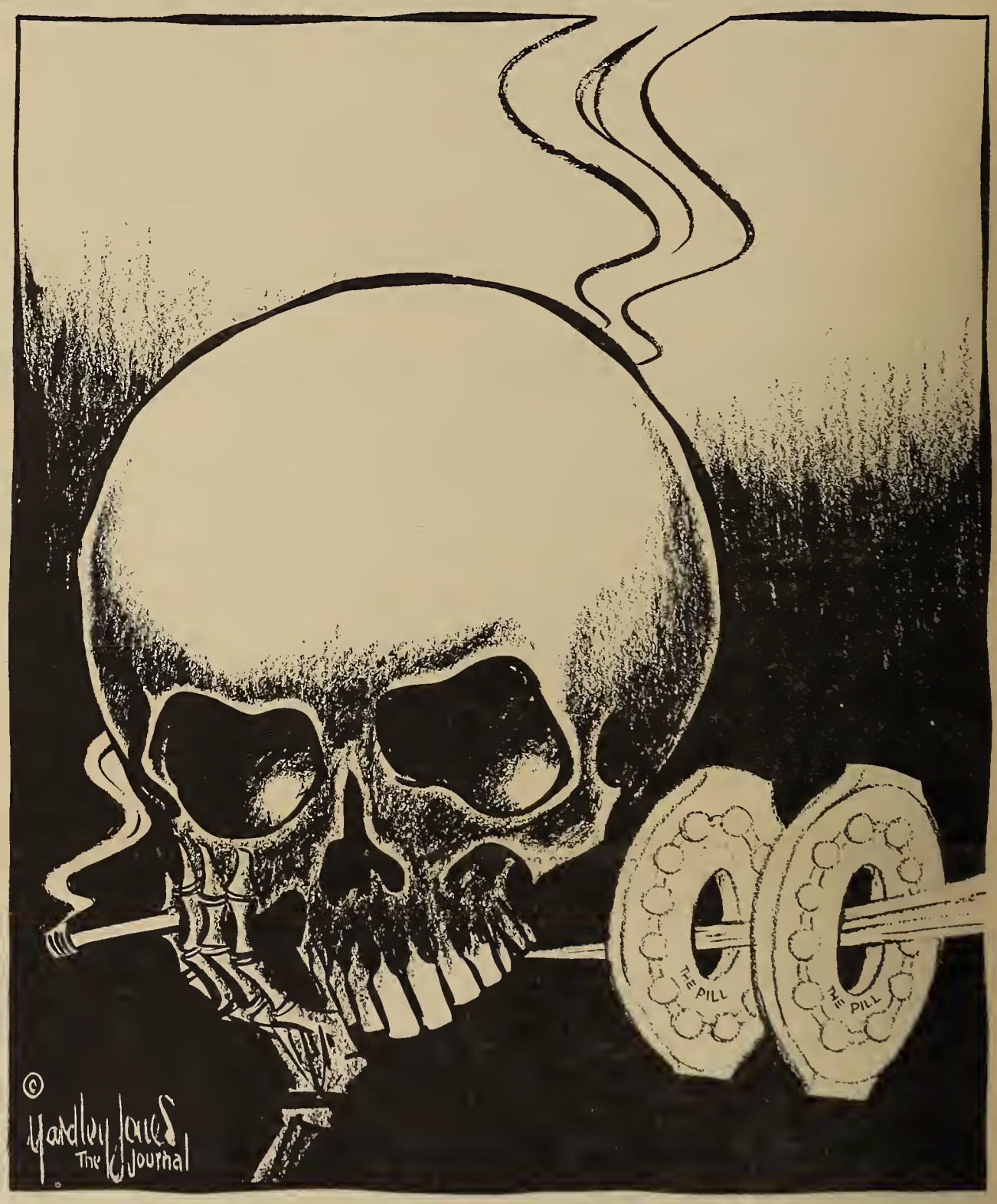
On the one hand, governments are spending vast sums of money for the prevention and treatment of alcohol-related problems. On the other, through liberal control policies, they act as promoters of alcohol products as though there was no problem with increases in their use and abuse.

While it might be difficult to demonstrate a specific adverse effect from the sale of wine in grocery stores, this change should be seen and condemned as contributing to the cumulative, detrimental effect of liberal alcohol control measures. This is particularly so if health protection is accepted as the underlying rationale for alcohol control policies in the first place.

The Ontario government has announced its new "legislative package" on alcohol control measures this spring (**The Journal**, Dec 1, 1977) and it remains to be seen how successful it will be.

(See — Comment — page 11)





Letters to the Editor

More Letters — page 11

AA 'over-protective mom'

This relates to the replies to my letter AA's only first step (**The Journal**, November 1977.)

I have to admit I expect negative replies. Perhaps I'm wrong but all my experience with other alcoholics and myself while drinking, taught me that the habitual drinker is by nature a very negative thinker.

If that were not true, alcoholics would not be afraid to venture out alone. Alcoholics Anonymous is always going to be there if one feels oneself slipping, but life is too short to waste it on continual meetings — once one has grasped the steps and put them into practice.

The only way I can explain my feelings is to use an analogy. Consider AA as a young mother, and the alcoholic as her very young baby.

The baby is able to crawl but not walk. However, if the mother holds the child, supports him/her, the child can totter about — when the mother lets go, the child falls.

Fortunately and eventually, the child has had enough — such methods are too slow — and with little warning, the child pulls itself up, and on its own begins to walk. Of course the child falls and hurts itself but doesn't give up. And it's not long before the child is running.

If the child has a fearful, over-protective mother, however, every aspect of its development will be impeded.

To me, AA was the over-protective mother. When I said I was leaving and going to try things on my own, I was constantly told "You can't do it," "You'll never make it".

Well I did do it and I'm certainly not sorry. Ninety percent of all the alcoholics I knew — the ones who made meetings their way of life — have slipped. So far, I haven't.

I've faced serious illness, tragedy, disappointment, fury, despair. Now, instead of disappearing into a bottle, something I did for 10 years, I stand up squarely to meet the various tests. I seem to gain strength.

I do not believe in looking back or dwelling on past misfortune. I do believe in trying to learn a lesson from each mistake, with the hope of avoiding repeating it in the future.

If one does not do this, I honestly don't see how one can ever become a reliable, mature individual.

Pat Armstrong
Vancouver, BC

COYOTE

Thank you for the article Drugs, prostitution linked: **COYOTE** (**The Journal**, Jan). It was excellent.

Margo St James
Founder, COYOTE
San Francisco

Correction

Human and mechanical error were responsible for the misspelled headline (**The Journal**, April, p.8). It should have read: Acupuncture for addicts recommended.

Special Report

Ravages of drug abuse elicit Australian action

By Ronald Lord

SYDNEY — Australian medical practitioner-turned-politician, Senator Peter Baume MD, is determined to keep alive a report on drug problems in Australia which has been prepared by a Parliamentary committee of which he is chairman.

A number of the report's 84 recommendations immediately sparked off controversy, particularly one that possession of marijuana for personal use not be defined in law as a crime.

This recommendation was made on the casting vote of Senator Baume, chairman of the Australian Government Members' committee on health and welfare and chairman of the Senate (Upper House) standing committee on social welfare. Three of the other six senators dissented. Two of the dissenting senators in a minority report said: "The committee is unanimously opposed to the legalization of cannabis. We go further, however, and oppose decriminalization also."

Another recommendation is worrying Australia's struggling sporting organizations. The recommendation calls on the Australian government to make any grants to sporting and cultural bodies conditional on their not accepting money from manufacturers and retailers of tobacco products.

The irony of this recommendation is that government support to these organizations is lamentably small. It is the very inadequacy of this support which has given tobacco manufacturers a dream opening to beat bans on television and radio by sponsoring major sporting events.

The Senate committee's report was delivered into an emotionally-charged national atmosphere. Newspapers were still full of stories about the disappearance and presumed murder of a civic figure and anti-marijuana crusader from a small town thought to be the heart of an illegal marijuana growing area.

As a result of the man's disappearance, the government in the State of New South Wales established a royal commission which has yet to deliver its report. Other state governments are conducting their own royal commissions and inquiries into drugs and drug abuse.

In recent weeks, marijuana smuggling again hit national headlines. A radar system operating briefly to track a Royal Australian Air Force transport aircraft picked up an unauthorized and unidentified light aireraft on its screen over North-West Australia. The transport spotted the light plane and gave chase. The pilot of the light plane landed and set fire to the cabin before fleeing, only to be arrested later. The plane was carrying crates of marijuana worth millions of dollars. In a court case later, the pilot said he had been offered $60,000 to deliver the goods in Australia. He refused to name the principals, though names have been mentioned.

This incident has renewed calls for greater surveillance of Australia's northern and western coastlines, which are wide open to illegal flights carrying contraband drugs from South East Asia.

In another recent episode, police and customs agents were involved in the seizure of millions of dollars worth of processed marijuana secreted in two vehicles imported into Australia from Europe.

Also, increasing numbers of young Australians are being arrested on drug charges in South East Asian countries. The severity of the penalties (in some cases life imprisonment and possibly even the death penalty) has been widely publicized.

The Senate committee's report details the ravages of alcohol in terms of ill health, erosion of social well-being, and economic cost to the individual and the community. It points out that abuse of alcohol is the major drug problem in Australia. It also examines the use in Australia of tobacco, analgesies, and cannabis.

Australian Minister for Health, Ralph Hunt, has asked his department to make an urgent examination of the report.

The report emphasizes the importance of national co-ordination of policy direction for controlling drug use and abuse.

"A single, identifiable authority should direct overall policies and co-ordinate the measures taken in pursuing those problems," it says. "We believe the appropriate authority is the (Australian) department of health."

The committee urged the government to declare the following seven-point drug abuse strategy, and encouraged Australia's six state governments to make similar declarations:

• Total elimination of drug abuse is unlikely but governmental action can contain the problems and limit their adverse effects. Control of drug abuse requires a long-term commitment within a publicly declared program with clearly identified goals and with time frame, monitoring procedures, financing arrangements, and standards all specifically stated.

• All drugs are not equally dangerous and all drug use is not equally destructive. Control efforts, therefore, should concentrate on drugs having the most adverse public health effects, particularly where use puts others at risk. Programs should give priority to individuals abusing high-risk drugs and to compulsive users of any drugs.

• Efforts to reduce the supply of and the demand for drugs are complementary and interdependent and federal programs should be based on a balance between them.

• Existing programs aimed at reduction of supply and demand must be broadened. In the reduction of supply, a higher priority should be given to increasing international co-operation in preventing the illicit production of drugs. In the reduction of demand, inereased attention should be given to prevention, constructive early intervention, and better aeeess to rehabilitation services.

• Drug abuse is primarily a social/medical — not a legal — problem, though such abuse may have important legal consequences and aspects.

• Management must be improved to ensure the maximum effect from resources committed to drug programs. Better interageney eo-operation is required. More attention must be paid to the setting of priorities with federal law enforcement efforts focused on high-level traffickers and federal resources foeused on habitual users of high risk drugs.

• The federal government has partieular responsibility for giving national leadership in coping with drug abuse. The states have an equally important role, especially in the direct provision of services. No national control program will be effeetive unless all governments eo-ordinate their activities. The Australian minister for health should have primary responsibility for federal action relating to all forms of drug use and abuse.

The report has long chapters on drug problems arising from the use of alcohol, tobacco, and cannabis. The report said prescription drugs also give rise to numerous problems but the committee had not received the necessary information to enable it to give adequate consideration to these problems.

"The Committee strongly believes that not enough emphasis is placed on aleohol and tobacco because of dominant but incorrect community attitudes that they are not drugs," the report said. "At present the drugs of abuse which adversely affect the health of the largest number of Australians are known. Alcohol and tobacco clearly rank first.

"Cannabis has been used by about 8% of the eommunity but the health risks are unknown. Abuse of minor analgesics is common and opiate abuse, which is devastating for affected individuals, may involve about 5.5% of the population."

The committee made 84 recommendations. These ineluded:

• That possession of marijuana for personal use not be defined in law as a crime.

• That the Australian government ban the advertising of alcoholie beverages and tobacco produets on radio and television and in areas under direct federal control such as in the Territories and at airports.



• That an appeal be made to sportsmen and sportswomen throughout Australia not to lend their names and prestige to the promotion of alcoholic beverages or tobacco products.

• That the Australian department of health and the health policy body in each state and territory continually monitor levels and patterns of alcohol consumption and formally advise their respective governments before each budget of the health considerations to be taken into account when examining excise and other revenue from alcohol.

• That tar and nicotine contents be stated on eigarette packets and that the Australian department of health establish upper limits for tar and nicotine contents and progressively reduce permitted levels until all cigarettes with tar and nicotine contents in excess of the established upper limits are banned.

• That proposals for restrictions on the sale of compound analgesics adopted by the National Health and Medical Research Council in April, 1977, be implemented; that all analgesics, whether sold with or without prescription, earry a warning on the container; that all non-prescription analgesics in pack sizes containing more than 25 tablets or 12 powders be available only from pharmacies.

Senator Baume said the report, if it did nothing else, would establish in the community an appreeiation that "drug use and abuse are to be seen all around us and that alcohol and tobacco are the real menaces to the future health of the Australian community."

There should be a reduetion in the use of licit drugs, and the use of illieit drugs must be brought under eontrol and continually reduced.

Senator Baume said the genuine divergence of community opinion on cannabis use was reflected in the report. Thirty hours — almost one-third of the time spent deliberating on the report — were devoted to the ehapter on cannabis.

The area of disagreement within the committee was limited, however, and related only to some aspects of the views of the majority on a proposed national strategy on cannabis and on proposed treatment of offenders under the law.

Information available to the committee suggested that 400,000 Australians or about 3% of the population used cannabis at least once a month.

The majority of the committee recommended that for possession of marijuana — that is, dried leaf as distinct from other forms — for personal use, the offence not be defined in law as a crime and the penalty be solely pecuniary and be a fixed amount at approximately the same level now being imposed by the courts in most states (that is, $100 to $150); that police should not photograph or fingerprint defendants; that no record of conviction kept by police or courts should be used in subsequent proceedings or in relation to any application by the offender for employment; and that consideration should be given to treating growing of small amounts of cannabis for personal use in the same way as simple possession.

According to Senator Baume, support for the committee's recommendations has flowed in from around the world.

Writing in the *AMA Gazette*, the newsmagazine of the Australian Medical Association (Jan 19, 1978) Senator Baume said: "As ehairman of that committee I have been delighted by the response both within Australia and from overseas.

"Almost all professional and socially involved groups have welcomed the committee's recommendations though some commercial interests in this country — the Australian wine lobby and advertising industry groups, for example — have objeeted to some of the recommendations."

Two issues later (March 2, 1978) Senator Baume wrote that the American Medical Association's House of Delegates, which he said was "hardly a hotbed of political ratbaggery," had adopted some revised views on penalties for marijuana use which he shared.

He quoted from an AMA document:

"It (the House of Delegates) recommends the discouragement of marijuana use, especially by persons vulnerable to the drug's effects, and in high risk situations; the determination of the consequences of long-term marijuana use through concentrated research; the modification of state laws to reduce the severity of penalties for possession of marijuana for personal use . . . ."

and

". . . . the trend toward modification of marijuana possession laws to reduce the severity of the penalities, therefore, should be encouraged in the interests of both the individual and society. Penalties in the form of fines should be applied to possession of small amounts with criminal sanctions imposed for trafficking."

Senator Baume said the American Medial Association document detailed impressively the current state of knowledge on damage and the dangers of marijuana use and would make useful reading "especially by those whose main contribution to the debate in Australia seems to have been the hysterical shouting of slogans."

Said Senator Baume: "The views and findings of the American Medical Association are very close to those of the report of the standing committee on social welfare . . . Perhaps we on the committee may not be as wide of the mark as some detractors would have you believe."

* * *

Mr Lord is editor of the AMA Gazette, the fortnightly news magazine of the Australian Medical Association.

hallucinogens

factsheet

The term hallucinogen is applied to any drug which has the principal effect of producing radical changes in the mental state, involving distortions of reality and hallucinations (the perception of phenomena that have no objective reality). These drugs have also been labeled illusionogenic, psychedelic, and mind-expanding. Drugs in the group include LSD, MDA, mescaline, psilocybin, phencyclidine (PCP), PMA, TMA, DMT, STP (DOM), and morning glory seeds. The term hallucinogenic has also been applied to jimson weed, nutmeg, and a variety of mushrooms and some other natural substances. Some other drugs may produce hallucinations if a very high dose is consumed — for example, alcohol and cannabis — but this is not the usual effect expected or experienced by the user.

Some hallucinogens are synthetic chemicals produced in private laboratories specifically for the illicit drug market. These include LSD, MDA, PCP, PMA, TMA, DMT, and STP (DOM). Others such as psilocybin, morning glory seeds, jimson weed, and nutmeg are naturally occurring substances with hallucinogenic properties. Mescaline can be either produced synthetically or extracted from the peyote cactus.

Almost all synthetic drugs, including hallucinogens, may be produced in white powder form and many are without a distinctive taste. Therefore, it is impossible to identify such drugs by sight or taste alone.

GENERAL EFFECTS

The effects of any drug depend on the amount taken, the way it is taken, the past drug experience of the user, and such immediate circumstances as place, feelings of the user, other people present, and whether alcohol or other drugs are taken at the same time. The same user may have different experiences with the same drug on different occasions. Further, s/he might enounter effects which seem both pleasant and unpleasant during the same drug experience. Not all people feel the same way about the effects of hallucinogens. Some users find their effects pleasant, partly because they are new and interesting. Others find such experiences unpleasant and emotionally upsetting.

In low dosage, the hallucinogens are mood-modifying drugs with a spectrum of effects which depend on variations both in the different hallucinogens and in the unique sensitivity of the individual to them. Low doses of hallucinogens usually produce alterations in mood and often changes in perception, but not necessarily hallucinations. In high doses, the effects usually include hallucinations and changes in mood and perception.

One effect of long term use of hallucinogens can be psychological dependence; in such cases, the drug becomes so central to the person's thoughts, emotions, and activities that it is difficult to discontinue use.

With hallucinogens, unlike most other mood-altering drugs, increases in dosage will not bring about reinstatement of the original effects.

It is necessary to leave a sufficient length of time between drug experiences to allow the drug to be metabolized before the original dose, or any dose, will be effective again. This phenomenon is known as tachyphylaxis. Cross-tachyphylaxis can occur with other hallucinogens. A user who is experiencing tachyphylaxis with LSD, psilocybin, or mescaline, will feel no effect from any of these drugs.

LSD

Pure LSD is a white, odorless powder and may be packaged in capsule, tablet, or liquid form, or taken on a piece of paper, sugar cube, etc. LSD is usually taken orally, but may also be injected. Street dosages may range from 40 to 500 micrograms.

Initial effects are felt in less than one hour and generally last two to 12 hours, gradually tapering off and, in a few cases, recurring over several days. Physical effects include increased blood pressure, dilated pupils, and rapid heartbeat. Muscular weakness, trembling, nausea, chills, and hyperventilation (breathing too deeply and rapidly) frequently occur. Motor skills and coordination are impaired. There are also significant effects on perception, mood, and psychological processes. The user may feel several different emotions at the same time or swing rapidly from one mood to another. Senses of hearing and sight may be intensified or merged and sense of time may also be affected. LSD diminishes an individual's capacity to differentiate the boundaries of one object from another and of the self from the environment. For some, this is a pleasant sensation but for others it may produce a panic reaction. In some users of LSD, prolonged serious depression and/or anxiety have occurred. Also, psychological dependence has been observed in long term users.

Another possible after-effect of LSD use is the 'flashback'. A flashback is a recurrence of the sensations which occurred during a drug experience — days, weeks, or even a year later. The user may find the flashback either pleasant or anxiety-producing.

Most scientific findings on the use of LSD during pregnancy, its possible effects on the fetus and the newborn, are still inconclusive.

MDA

MDA is chemically related both to mescaline (see below) and to the amphetamines. It is found as a light brown, brown, or white powder, and has appeared as an amber liquid. It is usually swallowed but may be sniffed or injected. The usual dose is 100 mg and upwards.

At low dosage, users generally report a sense of well-being with heightened tactile sensations, intensification of feelings, and increased self-insight, but without hallucinations or distortions. Higher doses of MDA produce effects quite similar to those of LSD, including hallucinations. These effects begin 30 to 60 minutes after oral injestion, sooner if injected, and persist approximately eight hours. Physical effects, not usually very pronounced, include dilation of pupils, increased blood pressure, and dryness in nose and throat.

Occasionally adverse after-effects do occur, usually a marked physical exhaustion coupled with anxiety lasting up to two days. At high dosage, serious physical reactions requiring immediate medical treatment have occurred. Although insufficient research has been done in the area, it appears that MDA users do not experience tolerance to, or dependence on, the drug.

MESCALINE

Mescaline can be extracted from the peyote cactus. The heads or 'buttons' of the cactus are dried and then sliced, chopped, or ground, and sometimes this product is placed in capsules. Mescaline may also be synthesized as a powder and distributed in capsule or tablet form. Mescaline is usually taken orally. It can be inhaled by smoking ground peyote buttons or it can be injected, but this is rarely done. Of the alleged mescaline samples analyzed at the street drug analysis facilities of the Addiction Reserach Foundation of Ontario, nearly 90% are *not* mescaline. They are usually PCP or PCP combined with LSD.

The usual dose of 300 mg to 500 mg is considerably less potent than the usual dose of LSD. At low dosage the effects appear slowly and last 10 to 18 hours. Effects include dilation of the pupils, an increase in body temperature, some muscular relaxation, and, frequently, vomiting. Mescaline can also produce euphoria, heightened sensory perception, hallucinations, alterations of body image, as well as difficulty in thinking.

High dosage can produce headache, dry skin, hypotension (low blood pressure), cardiac depression, and a slowing of respiratory rate. There is no evidence of tolerance or dependence.

PSILOCYBIN

Psilocybin is the active ingredient in the *Psilocybe mexicana* mushroom and some of the other psilocybe and conocybe species. Psilocin is an accompanying alkaloid, usually present in small amounts. Psilocybin and psilocin are derivatives of tryptamine and therefore are chemically related to LSD and DMT. In its pure form, psilocybin is a white crystalline material. It may also appear as a crude mushroom preparation, as an intact dried brown mushroom, or powderd material of any color in a capsule.

Psilocybin is usually taken orally but may be injected for more rapid onset of effects. Injection can be quite dangerous, however, because of the possible presence of foreign particles. Doses generally vary from 4 mg to 6 mg although 20 mg to 60 mg are not unusual. When taken orally, effects begin after about 30 minutes and last several hours.

Acute effects of a small dose (4 mg to 8 mg) include sensations of intellectual

The Journal

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and physical relaxation and tiredness, detachment from surroundings, and perhaps feelings of physical heaviness or, conversely, lightness. Changes in mood and perception can occur.

Higher doses (13 mg and above) can produce dizziness, lightheadedness, abdominal discomfort, numbness of tongue, lips, or mouth, nausea, anxiety, and shivering. Gradually, marked changes in perception develop and the user experiences effects quite similar to those of LSD. Other reported effects include a sense of slowed passage of time, yawning, facial flushing, sweating, depersonalization, feelings of unreality, and inability to concentrate.

There is no known addiction to psilocybin but tachyphylaxis and cross-tachyphylaxis (see **GENERAL EFFECTS**) between psilocybin, LSD, and mescaline have been experienced.

As with other street drugs, the drug purchased as psilocybin is only occasionally psilocybin. Often it is something quite different: mostly PCP, sometimes LSD.

PHENCYCLIDINE

Phencyclidine is a general anesthetic with hallucinogenic properties. It appears as white or colored chunks; or powder, tablets, capsules, or white crystals sometimes mixed with leaf or seed material. It is usually taken orally or injected but may also be smoked or sniffed. The usual dose is 2 mg to 6 mg but, even more than for most street drugs, the strength of the dosage in street samples of PCP is highly unpredictable.

In low doses, PCP produces a state resembling alcohol intoxication, including motor incoordination, slurred speech, drowsiness, confusion, and general numbness of the extremities. Nausea and vomiting may occur.

At high doses, anesthesia can occur, with sensory disturbance or blockage. Perceptual distortions and feelings of apathy or estrangement and isolation may occur. In some cases, effects have lasted for 10 days to two weeks. PCP is toxic, and death may result from high doses.

The extent to which PCP may produce tolerance and/or dependence has not been studied sufficiently to provide even a general statement. Fatalities have been associated with uncontrollable convulsions and a sudden surge of blood pressure resulting in intracranial hemorrhage. It is possible that flashbacks, periods of prolonged anxiety, or severe depression might occur as after-effects.

PMA

PMA (paramethodyamphetamine) has both hallucinogenic and central nervous system stimulant properties. It has appeared as beige powder or as white or pink powder in pink or colorless capsules which are taken orally.

PMA has a more pronounced hallucinogenic effect than MDA, a drug to which it is very similar in some repects. As a central nervous stimulant, PMA also has more pronounced effects than MDA on basic bodily functions. The physical effects on users generally include highly increased pulse rate and blood pressure, increased and labored respiration, highly elevated temperature, erratic eye movements, muscle spasm, nausea, and vomiting. At high doses, the reaction often results in convulsions, coma, and death.

When sold on the street, PMA has been passed off as MDA. Yet at a dosage often considered to be safe with MDA, PMA is toxic due to radical interference with blood pressure, temperature, and pulse rate. It has been observed that the body appears to race itself to death.

TMA

TMA (trimethoxyamphetamine) is a hallucinogen with stimulant properties. It has been sold on the street as MDA, or as other hallucinogens, appearing to be a yellow or beige powder. It can be taken orally or injected. If injected, the effects are more toxic. TMA is a more potent hallucinogen that mescaline. After about two hours the user has mescaline-like hallucinations (see above) including intensified auditory and tactile sensations.

TMA, MDA, and mescaline all belong to the same chemical group, the phenylethylalanines and are chemically related to adrenaline.

Insufficient research does not permit conclusions about after-effects, reactions, overdose, and addiction potential.

DMT

DMT (dimethyltryptamine) is a synthetic chemical similar to psilocin, an alkaloid contained in the *Psilocybe mexicana* mushroom. It is also thought to be present in some natural substances.

Usually the drug is soaked in parsley which is then dried and smoked in a pipe or cigarette. It can also be made into a tea or injected.

The effects begin almost immediately and last for a relatively short period (30 to 60 minutes). The effects are similar to those of LSD but do not last as long. Physical dependence does not develop to DMT but tolerance does. Recent evidence has suggested that DMT does not produce cross-tachyphylaxis with LSD (although psilocybin and mescaline do). This may suggest that DMT has a different effect on the brain.

STP (DOM)

STP or DOM is chemically related to amphetamine and to mescaline. It is considerably more potent than mescaline but much less potent than LSD. When available, it is taken orally.
Physical effects can include sleeplessness, dryness of mouth, nausea, blurred vision, sweating, flushed skin, and shaking. Exhaustion, confusion, excitement, delirium, and convulsions may also occur. These effects can last from 16 to 24 hours. People who have already experienced psychological disturbance may suffer a prolonged psychotic reaction. Tachyphylaxis has been reported with STP, but not addiction. There are no reports of deaths directly attributable to STP.

MORNING GLORY SEEDS

Morning glory seeds are brown or black: they may be eaten whole, ground up, soaked in water which is strained and drunk, or the mush eaten. The active ingredient may also be extracted chemically.

The active ingredient in certain morning glory seeds, lysergic acid amide, is chemically related to LSD and about one-tenth as potent. Depending on the variety of the seeds, about 300 would give effects similar to 200 to 300 micrograms of LSD.

The effects — physical, psychological, and chronic — are similar to those of LSD. When orally ingested, effects begin after 30 to 90 minutes. When the liquid is injected, effects begin immediately and are more severe. Morning glory seeds are packaged commercially and sold legally. Some seeds have been treated with insecticides, fungicides, or other chemicals that are poisonous if enough is taken. Some seeds have also been specially treated to produce nausea if eaten.

NUTMEG

Nutmeg seeds are eaten whole, powdered, or ground. The powder has also been sniffed.
The active ingredient in the seeds of nutmeg *(Myristica fragrans)* is closely related to TMA (see above), a hallucinogen with stimulant properties. It is also possible that nutmeg contains an element that is related to STP and mescaline (see above).
Low doses may produce mild, brief euphoria, lightheadedness, and central nervous system stimulation. At higher doses, there may be rapid heart rate, excessive thirst, agitation, anxiety, acute panic, vomiting, and hallucinations. The effects begin slowly, last several hours, and may be followed by drowsiness.
Although readily available, it appears that nutmeg is generally used only when other hallucinogens are not available.

OTHER HALLUCINOGENIC ALKALOIDS

There is a wide variety of other drugs which can produce hallucinations at high dosages. These include the belladonna alkaloids which are present in jimson weed *(Datura stramonium)* and some potent medications for the common cold. The hallucinogenic alkaloids in jimson weed are present in various proportions in all parts of the plant. Usually the leaves or berries are eaten. Clinical effects depend on the individual and the amount and type of the alkaloids.

HALLUCINOGENS AND THE LAW

LSD, MDA, DMT, STP (DOM), PMA, psilocybin, and psilocin are in the restricted drug category, Schedule H, under Part IV of the Food and Drug Act. This means it is illegal for anyone to have any involvement with these drugs. The only exception occurs when permission is granted through the appropriate governmental sources. Such permission is granted to hospitals and research institutions for the purposes of clinical and experimental investigation but even this is strictly controlled.
A summary conviction for possession (first offence) carries a penalty of up to $1,000 and/or six months imprisonment. For a subsequent offence the maximum fine is $2,000 and/or one year imprisonment. An indictable conviction for possession carries a possible fine of $5,000 and/or imprisonment for three years.
The definition of trafficking includes manufacturing, selling, importing, or delivering the drug. Trafficking and possession for the purpose of trafficking are subject to maximum penalties — upon summary conviction, 18 months imprisonment and, upon conviction on indictment, 10 years imprisonment. In practice, sentences imposed are usually less than the maximum the law provides.
Legal penalties for the possession, selling, importing, and exporting of phencyclidine (PCP) are included in the Narcotic Control Act. A summary conviction for possession carries a penalty of up to $1,000 and/or six months imprisonment for a first offence, and $2,000 and/or one year imprisonment for a subsequent one. However, an indictable conviction for possession may result in imprisonment for up to seven years. Conviction for either importing or exporting phencyclidine will result in a sentence of from seven years to life.
In both the Food and Drug Act and the Narcotic Control Act, the decision of whether an offence is summary or indictable, when the choice exists, rests with the Crown and varies with individual circumstances such as the type and the amount of the drug. Trafficking and possession for the purpose of trafficking are *automatically* indictable offences under the Narcotic Control Act, and conviction may result in a maximum prison term of life.
Of all the hallucinogens mentioned above, only mescaline can be legally sold under prescription. It is covered by Schedule F of the Food and Drug Act and therefore is not restricted as are the other hallucinogens.

Morning glory, peyote, and nutmeg are not subject to any direct legal restriction in Canada. ©1976 Alcoholism and Drug Addiction Research Foundation of Ontario.

In Perspective:



COCAINE

Oriana Kalant has spent four years reviewing the international literature in English, French, Spanish, and German on cocaine and coca leaves. In this article, she looks at cocaine use as it is now and as it was in the past and says cocaine must be viewed in an historical perspective. Dr Kalant, a scientist in the research division of the Addiction Research Foundation of Ontario, is also an expert on amphetamines.

BY ORIANA KALANT

Every new drug fad in the last decade or so has been accompanied by strident controversy, biased and ill-informed claims and counterclaims, and generally utter confusion about what the facts of each case really are.

Over the last few years, recreational use of cocaine has increased sharply. Inevitably, there is also a renewed interest in cocaine on the part of law enforcement agencies, the lay and professional press, and the scientific community.

Articles in the popular press, and reprinting of an unbalanced selection of old books, have tended to glamorize the drug. It is now being described as "the champagne of drugs," "the greatest high," "the most misunderstood drug in the illicit pharmacopoeia," "probably the most benign of illicit drugs currently in widespread use."

Attacks on the legal status of cocaine are reminiscent of the ideological arguments about marijuana in the last decade. But the situation with respect to the two drugs is totally different.

Pure cocaine has been known and used medically as well as non-medically for about a century in all western countries. The clinical and pharmacological effects are *far better known* than those of marijuana: for all practical purposes, they are indistinguishable from those of amphetamine.

It does no service to society to obscure the body of knowledge already available by irrelevant, often tedious, and ill-informed ideological arguments. Therefore, it is important to state what we know about cocaine as objectively as possible and in its proper historical perspective.

Cocaine is the main active drug contained in the leaves of the coca bush which grows on the eastern slopes of the Andes, mainly in Peru and Bolivia. For centuries, the Indians of these regions have been in the habit of chewing coca leaves to increase their physical endurance, and decrease feelings of hunger. It helps them cope with the rigors of hard work at high altitudes.

Cocaine was isolated, purified, and identified by Niemann, a German chemist, in 1860. The central nervous system stimulating properties of the coca leaves were soon confirmed by testing the effects of pure cocaine in man.

Interest in the possible medical applications of cocaine was increased dramatically by the publication of two reports in the summer of 1884. In one, Sigmund Freud recommended cocaine as a stimulant for the treatment of depression and several other illnesses, including alcohol and morphine addiction. The other was by Carl Koller, a colleague of Freud's, on the local anesthetic properties of cocaine on the eye.

Subsequent events followed two parallel but independent pathways. Use of cocaine as a local anesthetic in ophthalmology, dentistry, and many fields of surgery led, eventually, to the discovery of numerous synthetic substitutes with lower toxicity.

At the same time, use of cocaine in morphine withdrawal led, indirectly, to the spread of self-administration of cocaine. At first, it was used mainly by subcutaneous injection. The practice of sniffing cocaine appeared at the turn of the century and spread rapidly, reaching a peak after the first World War. From then on, cocaine use diminished gradually, and during the next 50 years it was rare and essentially confined to intravenous users of heroin.

The resurgence of cocaine use in recent years appears to be largely confined to multiple drug users, who take the drug occasionally. However, recent surveys in the United States suggest that a small but growing proportion regularly use large amounts of cocaine as their major drug.

Recreational use of cocaine seems largely confined to an elite of affluent and sophisticated people. One report describes cocaine being offered as a treat at dinner parties in lieu of liqueurs and brandy. This is quite understandable since current prices range between $60 and $90 a gram, "one user's evening's worth" as a journalist recently put it.

Since chronic compulsive use of drugs is a function of many factors including availability, price, and the total number of users, it is not at all surprising there have been practically no clinical or scientific reports of cocaine addiction in the past 30 to 40 years. This has led many people, including some distinguished authorities, to say that practically nothing has been learned about the effects of cocaine in man since Freud's publications on the subject.

This is nonsense. Clinical and research reporting on the effects of any drug invariably parallels the prevalence of its use. Since cocaine use was at its height during the first quarter of this century, the best documented clinical evidence is to be found in the literature of the 1920s, mainly in German and French. The data are extensive, sound, and meticulously reported. They are clinical observations of the same kind that make up most of our knowledge of the harmful effects of amphetamine. It makes no sense to accept such knowledge about amphetamine and reject it about cocaine. We already have a very good picture of the possible physical and mental complications of chronic cocaine use, without having to wait for accumulation of new observations.

As is the case with all dependence producing drugs, including alcohol, many people can use cocaine a few times, or even periodically, without becoming compulsive users. These are the people who can take or leave it. But a certain proportion will become compulsive users who are quite unable to give it up despite all sorts of untoward effects and difficulties.

The dependence-producing liability of cocaine in man is fully consistent with experimental evidence in animals. Experiments in rats and monkeys, trained to self-administer drugs intravenously, show that cocaine and amphetamine are the most powerful dependence-producing drugs. Even more so than morphine.

The repetitive, compulsive self-administration of drugs for reasons other than to avoid physical withdrawal symptoms is generally referred to as psychological dependence. Common wisdom to the contrary, psychological rather than physical dependence is the essence of addiction. In this sense cocaine has no rival. During the first 40 years of widespread cocaine use, chronic users generally began with moderate doses of 200 to 300 milligrams a day. Escalation of the dose often took place quickly, over a period of a few weeks or months. The most commonly reported doses were of the order of two to three grams of pure cocaine a day. But there are many reports of individuals who used up to 10 grams a day. There is one case on record of a man who took 19 grams of pure cocaine in one night. Current levels of use in North America are not as high as these, because the illicit drug sold here now is quite dilute and very expensive. Of course, the enormous doses used earlier in this century suggest that cocaine induces marked levels of tolerance rather quickly. And yet there is no consensus at present on this point.

Some researchers believe cocaine does not produce tolerance at all. Some think it produces remarkable levels of tolerance, and yet others that it induces sensitization rather than tolerance. The question remains unresolved. Whatever the correct answer may be, it will have to account satisfactorily for the huge doses that some chronic users reach.

The physical symptoms of the withdrawal syndrome following discontinuation of cocaine in chronic users are comparatively mild. The main features are prolonged but disturbed sleep, rebound exaggeration of appetite, and depression of mood. As long ago as 1924, two distinguished German clinicians described the syndrome in these words: "After the sleep which follows the intoxication, an enormous increase in appetite can lead to the ingestion of remarkable amounts of food. The hunger which appears after

drug withdrawal has, in fact, all the dignity of an abstinence symptom."

As one would expect, these symptoms are the reverse of the effects produced by the drug.

Prolonged heavy use of cocaine can lead to both physical and mental complieations. The mental disturbances are direetly related to the characteristie effects of coeaine. The effects on physical health, on the other hand, are partly due to the drug effeets, and partly related to the mode of administration.

There are no remarkable ehronic physical effects of coeaine itself. Essentially they are a continuation of the acute effects. The more prominent symptoms inelude increased heart rate, pallor, sweating, and dilated pupils. There is often loss of appetite, and eonsequent loss of weight. Constipation, difficulty in urinating, and impotence in the male are signs of the continued stimulation of the sympathetic nervous system.

On the other hand, there are more characteristic, and even diagnostic, signs related to the manner of using the drug. If eocaine users inject the drug subcutaneously or intravenously, there is a high probability of producing the usual complieations of bad injection techniques. Scars, abcesses, and atrophy of the skin were common in earlier times. Intravenous injection can give rise to thrombophlebitis, hepatitis, or embolism.

Chronic sniffers of cocaine can show a characteristic triad: eezema around the nostrils, stuffiness and running nose, and perforation of the nasal septum, often preceded by severe nose-bleeds. In addition, such users may show a variety of disturbances of taste and smell, and tickling, burning, and crawling sensations of the face, neck, and back. Tics and spasms of the facial muscles and external muscles of the eye used to be common, and may become so again if use continues to inerease.

The most striking effects of chronic use, however, are the mental ones. At first these consist of restlessness, hyper-excitability, sleeplessness, and suspieiousness, whieh progressively displace the initial euphoria. If the drug use continues, the same picture evolves as that seen in chronic amphetamine users. This eonsists of hallucinations of all the senses, delusions of perseeution and of grandeur, and aimless compulsive repetitive behaviors. Itching or crawling sensations in the skin are frequently misinterpreted as being caused by worms, lice, tiny crystals, or other strange objects under the skin. Despite these symptoms, the individual usually remains well oriented.

Clinically this condition is identical to amphetamine psychosis, and both are strikingly similar to paranoid schizophrenia. However, the symptoms disappear quickly if the drug is stopped. Modern psychiatric researchers are, in fact, keenly interested in amphetamine and cocaine psychoses because they may provide invaluable clues to the biochemical mechanisms underlying true schizophrenic symptoms.

Why did the popularity of cocaine diminish so sharply after the 1920s, and why has it become fashionable again? No doubt a variety of factors have played a role, including the introduetion of amphetamine into medicine in the 1930s.

Though eocaine is classifed for legal purposes as a narcotic along with heroin and similar drugs, its acute effects are almost identical to those of amphetamine. Both drugs cause a stimulation of the sympathetic and central nervous systems. The major eomplications of chronic heavy use, including development of strong dependenee, and a variety of physical and mental problems, are also very similar.

In the circumstances, it is probably no coineidence that non-medical use of cocaine began to diminish at about the same time amphetamine was introduced, espeeially since cocaine was by then under strict legal eontrol while amphetamine was cheap and freely available. It seems likely the eurrent popularity of cocaine is somehow related to the fall in popularity of amphetamine and increasing restrictions on its medical use, as a result of the very negative publicity surrounding the use of "speed".

Cocaine can be taken orally, subcutaneously, intravenously, and by application to the mucosa of the mouth, nose, rectum, and vagina. The most popular eurrent method is sniffing the drug into the nostrils.

Mode of administration, as well as dose, have an important bearing on the onset and duration of acute effects, rate of development of dependence, and physical consequences of prolonged use.

Our knowlege of the acute effects of cocaine on man is based primarily on elinieal descriptions published during the three or four deeades following the introduction of cocaine into medicine. Recent controlled studies have essentially confirmed the earlier findings.

The major effeets related to the stimulation of the central nervous system include feelings of well-being, euphoria, self-eonfidence, increased energy, and postponement of fatigue. In depressed patients, however, the drug may induce anxiety and tension rather than euphoria.

Small doses taken by mouth may increase muscular strength and shorten sensorimotor reaction time. Sensory acuity, and speed of word associations, increase. There is increased talkativeness, and general psychomotor activity, and the subject experiences faster and clearer thinking, and greater ease of expression.

Appetite and need for sleep are both diminished by cocaine and the proportion of REM (rapid eye movement) sleep is reduced. Sexual drive is said to be increased, while the time to achieve orgasm is prolonged in the male, so that prolonged sexual activity is possible.

The acute somatic effects resemble those produced by stimulation of the sympathetic nervous system. There is an increase in heart rate and blood pressure, and a tendency to cardiac arrhythmias, especially at higher doses. Peripheral vasoconstriction and adrenergic stimulation of sweat glands lead to pallor and eold, elammy skin. The pupils are often widely dilated, body temperature may be raised, and breathing is more rapid. There may also be dry mouth, and sensations of scratching, constriction and dryness of the throat and esophagus.

As with other psychoactive drugs, these effects may vary within the same individual depending on the pre-drug mood, as well as in different individuals. The major differences appear to depend on the balance between euphoric and distressing sensations, and between central and peripheral sympathomimetie effects.

The setting in which the drug is taken is also important. In a soeial context, hyperactivity, loquacity, euphoria, and sexual activity predominate, while the solitary user is more prone to fall into a pleasurable dream state.

There is an extremely close resemblance between the effects just described and those of amphetamines which have been far better documented in experimental studies in man. There are, however, some noteworthy differences.

First of all, cocaine is a potent loeal anesthetic while amphetamine is not. This explains not only the difference in the medical applications of the two drugs, but also the toxic effects.

Secondly, absorption from the intestine is quite efficient for amphetamines, but poor for cocaine. In contrast, the absorption through other mucosal surfaces is more efficient for cocaine than for amphetamine. No doubt this explains the fact drug users are more likely to sniff cocaine and to take amphetamine by mouth.

Both drugs can be used subcu.aneously, a practice described in the vernacular as skin-popping, and also intravenously. The latter procedure leads, of course, to the most rapid onset of action.

Another difference is that the rate of metabolism is much slower for amphetamines than for cocaine. This probably explains why chronic users take cocaine at shorter intervals than amphetamine.

As with other drugs, aeute toxic reactions to cocaine can be deseribed in two different contexts. The first refers to the appearance of any or all of the acute effeets already deseribed when the drug is used as a local anesthetic. Imagine, for example, a patient in the dentist's chair suddenly beeoming euphoric, loquacious, and hyperactive. Hundreds of such eases of so-ealled poisonings were described in the medical literature up to about 1925 when cocaine was the most common local anesthetic in use.

The other connotation of the term "toxicity" refers to a serious *exaggeration* of the effeets of cocaine on the central and sympathetic nervous systems. This can occur either as a result of individual hypersensitivity or through intentional or unintentional overdose.

The most common symptoms related to the overstimulation of the central nervous system are restlessness and agitation accompanied by emotional lability and often intense anxiety. Constant aimless movement, talkativeness, gesticulation, and obsessive thinking may oceur, and in severe eases there may be delirium and hallucinations.

Other motor symptoms inelude overaetive reflexes, tremors, ineoordination, and muscular twitching. In severe cases these evolve into spasm of the neek and back museles, and generalized tonic-elonic convulsions.

All the symptoms of stimulation of the sympathetic nervous system which we noted earlier, ean be exaggerated to the point of causing severe discomfort, such as pain or pressure in the ehest, blurred vision, nausea, and fever.

These symptoms are praetically identical to those produeed by acute amphetamine intoxication, except that convulsions are much rarer in the latter. But the most important differencc relates to the local anesthetic properties of cocaine which, with high doses, may give rise to depressant effeets on the central nervous system.

In the most severe cases, especially those which end in death, there is marked central depression, with coma, anesthesia, muscular flaccidity, slow and irregular breathing, and finally, respiratory arrest.

Therefore, causes of death by overdose differ between cocaine and amphetamine. Sympathomimetic effects, principally intracranial hemorrhage, cardiac arrest, and high fever predominate in fatal cases of amphetamine poisoning.

In fatal cases of cocaine poisoning, on the other hand, death is more often due to progressive respiratory depression, or respiratory arrest during epileptie seizures. Beeause death by overdose of opiates is also due to respiratory arrest, it is possible that some sudden deaths attributed solely to heroin overdose may really be due to a eombination of heroin and eoeaine.

Deaths by overdose are rarer with cocaine and amphetamine than with narcotics such as heroin, and with barbiturates. However, they appear to be increasing. Though there were no cocaine fatalities recorded in 1973, United States authorities estimate that there are 100 to 150 cases a year eurrently. Moreover, deaths by aecidents, suicides, and homicides are higher among heavy users of amphetamines, and probably of cocaine, than in the general population.

Obviously, it will be necessary to monitor the current changes in levels of use in North America, and the consequences of that use. But we should not be afraid of stating what is already known, on the grounds of possible loss of credibility. Reaetions of the human body and mind have not changed appreciably in the last half century, and therc is no reason to believe that cocaine affects them differently now than it did then. If eocaine use increases to the levels it attained in the first quarter of this century, there can be no doubt that the effects described above, will again become common.

Comment

(continued from page 6)

As far back as 1973, groups such as the Addiction Research Foundation have urged that laws concerning the use and sale of alcohol be tested against a health objective — the prevention of further increases in the prevalence of alcohol problems.

In Ontario, Alcohol and Drug Concerns, Inc, a non-profit eitizens group in Toronto, has submitted a brief to all members of the provincial government outlining its proposals for legislative reform. (See page 1)

The group recognizes that isolatcd changes in control policies, be they liberal or otherwise, have little effect on the development of costly soeial problems caused by widesprcad use of alcohol, and ealls for a multiple approach to reform.

Included in the group's recommendations are proposals to restrict alcohol advertising, to halt the spread of self-serve liquor stores, to raise the legal drinking age to at least 20 years, to require mandatory proof of age documentation for all people reaching the legal age, to require licensed establishments to offer attractive alternative drinks to alcohol, and to institute a pricing policy whereby the cost of alcoholic beverages as a percentage of disposable income is kept consistent.

Underlying this multi-level approach to reform is the group's valid concern about the alarming trend to continued and constantly increasing levels of alcohol consumption. In faet, it adopts the 1973 proposal of the Addiction Research Foundation, and reiterates that the key question in alcohol control measures should be whether the proposed changes are likely to contribute to higher consumption levels and therefore to an increase in health costs.

It appears the Quebec government, in allowing wine sales in grocery stores, has not asked this question, or, if it has, it has rejected the evidenee relating increased consumption to increased alcohol-related problems. The Ontario government should not make the same mistake when it considers its 'legislative paekage' for reforming alcohol control policies.

More Letters...

Cannabis factsheet

A balanced document?

I am eoncerned about the cannabis factsheet **(The Journal,** Jan).

I believe this factsheet cites a great deal of soft and suggestive evidence relative to the toxicity of cannabis without adequate explanation that these observations are far from proven.

Further, I believe the whole area of therapeutic use of eannabis, where documentation is oeeurring at a substantially higher rate, has been left out. For example, at the present time, there is substantially more evidence that cannabis reduces intraeular pressure, and may be valuable in the treatment of glaueoma, than there is that eannabis eauses ehromosome damage.

In fact, the evidenee relative to the therapeutic use of cannabis is esealating at such a rapid rate, that in the relatively near future in the United States cannabis may be rescheduled from Schedule 1 to Schedule 2, indicating its medical uses.

I request that **The Journal** give a more balaneed view of cannabis in future issues, with more documentation of the degree of proof for some of its toxieological statements, and more emphasis on the growing body of information that supports the potential therapeutic uses of cannabis.

David E. Smith, MD
President, Youth Projects
Medical Director, Haight-Ashbury Free Medical Clinic

The Journal 'is excellent'

The Journal is excellent and much appreciated. Congratulations on honor from the World Health Organization referring to "excellence" **(The Journal,** Jan).

A. Spencer Paterson, MD
London, England

'Inner meditation' is surpassing psychoanalysis

(from page 16)

bureaucracy," Dr Kono explained, "and lags in administrative cooperation."

After gathering $3.5 billion in alcohol revenue last year, the government budgeted a mere $19,000 for alcohol research.

Ninety beds for alcoholics are provided in the country's two national mental hospitals.

For those who can afford it, treatment is given mainly at private mental hospitals.

No medical degree or accreditation is required to operate one of these facilities.

"Treatment centres are understaffed and most doctors and nurses are not properly trained to take care of alcoholics," said Dr Kono.

The level of recognition of alcoholism is even worse.

Large numbers of alcoholics are diagnosed only after they have developed delirium tremens and are beyond recovery.

These unfortunates are frequently tagged "neurotic" and filed away in mental hospitals for custodial care.

Those lucky enough to be detected early are mainly treated in internal medicine wards of general hospitals as "hidden alcoholics."

There are only three halfway houses in Japan, all run by religious groups.

Follow-up services and a system of rehabilitation simply do not exist.

Most of the rehabilitation rests on the family, aided by such groups as Danshukai (Japan's version of Alcoholics Anonymous with the importance differences that it lacks a religious orientation and members seek publicity not anonymity) and the White Crysanthemum Society, which corresponds to AL-ANON.

While organized care of alcoholics is woefully inadequate because of lack of funding, in some area of rehabilitation Japan is doing better than the West.

Japanese women alcoholics do much better than Western women after discharge from hospital.

Women alcoholics generally stay in hospital for three to five months and a high percentage are able to pick up the threads of a normal life again.

"This is because Japanese husbands make great efforts to help their wives adjust to normal living," explains Dr Shibata.

For single women, strong support comes from family ties.

Approximately 2% of hospitalized alcoholics are women.

A strong social stigma attached to women alcoholics is a powerful deterrent to drinking again, says Dr Shibata.

A notable method of treatment here called "inner meditation," is returning more alcoholics to the community than Western psychoanalysis.

Based on *Jodo Shinshu* Buddhism, it helps the alcoholic gain insight into his behavior and effect a change in his lifestyle.

One of its proponents, Dr Hiromu Suwaki, 27, a lecturer at Okayama University, where the method has been used in affiliated hospitals for the past decade, claims that half of the patients addicted for more than 10 years remained dry for more than three-and-a-half years after treatment compared with only a 30% cure rate with conventional psychoanalysis.

After withdrawal and regaining his physical strength, the patient is isolated in a small room where he sits cross-legged on the *tatami* or straw floor for up to 15 hours a day and summons up childhood memories of his mother, father, relatives, teachers, and employers in chronological order.

The introspection is periodically guided by the therapist who asks the patient to recall his excesses and how his behavior has hurt the influential people in his life.

Under this system it takes patients about one week to resolve to stop drinking.

After discharge a less intensive form of meditation is practised at home for maintenance.

The technique has much in common with another form of meditation called *Naikan* or "self-observation" that has been highly effective for treatment of neuroses, psychosomatic disorders, and rehabilitation of criminals.

Such methods seem simplistic and inappropriate for Westerners who take a more analytical and rational approach to life and can probably mount more resistances than the Japanese who emphasize feeling orientations.

But the methods work with the Japanese and will probably continue to be effective as long as the Japanese maintain strong emotional ties to their families and respect for teachers and employers — the cement that helps hold their society together.



A drunk on Japanese subway is usually given a very wide berth. Photo: David Milne

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Alcohol is blamed in car death study

By Lynn Payer

PARIS — At least 38% of fatal traffic accidents in France are caused by someone with a blood alcohol level above the legal limit of 0.08%, a study of all fatal accidents in France between Jan 1 and June 30 1977, has shown.

In reality, said Professor Claude Got, head of the department of pathology at Hôpital Raymond Poincaré in Garches, the proportion is probably 41% to 45%.

He explained the figure of 38% was obtained by taking the proportion of people responsible for fatal accidents who were found to have above-legal alcoholemias by blood test (50%), extrapolating it to the group in whom blood samples were not available, and adding in a third group, in whom breath test results were available (19% positive).

Nearly half of the people above the legal limit had an extremely high blood alcohol level — more than .2%.

"These levels are rarely found in persons under other circumstances," he said, "which shows the greatly increased risk of causing a fatal accident when the alcohol blood level is this high."

However, he said, the relatively small proportion of drivers with blood alcohol levels between 0.05% and 0.08% would indicate that lowering the legal limit to 0.05% should not necessarily be a priority.

"It would be better to concentrate on enforcing the existing limit," Dr Got said in a telephone interview. He said a bill to do this, which was to have been debated in the National Assembly in December, has been postponed until after the elections last month.

Dr Got's study found also that women who cause fatal accidents are less likely to be under the influence of alcohol than men.

"To be under the influences of alcohol when one provokes a fatal accident is an almost entirely masculine phenomenon," he said.

An analysis by type of vehicle showed that the role of alcohol was particularly frequent when the accident was caused by a pedestrian, by a car driver, and by motorcycle drivers. At the opposite end of the scale were truck drivers, where only 10% of those responsible for a fatal accident were found to have a blood alcohol level more than 0.08%

'Greatest challenge of our time'

World war on smoking set

By Alan Massam

LONDON — The cancer societies of the world are being urged to make a concerted effort to meet "one of the greatest challenges to preventive medicine of our time" — smoking.

The initiative has come from the Geneva-based International Union Against Cancer* which has just held its Western European Workshop here to discuss strategy. Delegates spent three days studying the project's key publication *Lung Cancer Prevention: Guidelines for Smoking Control* upon which it is hoped individual cancer societies will base their own anti-smoking drives.

The handbook declares, triumphantly, that it is dealing "not with 'why' and 'whether' the smoking problem should be tackled, but with 'how'."

It is to be used as the basis of regional workshops in both developing and developed countries, encouraging regional groups to co-operate and pool their experience and resources to mount a more effective attack on the problem.

Project chairman Nigel Gray, director of the Anti-Cancer Council of Victoria, Australia, told **The Journal** that the substance of the smoking problem varied greatly in developing countries as did the degree of anti-smoking activity. But the need to establish a program to suit local situations applied equally to Asia and Europe although some program targets were more obvious.

For example, the tar content of cigarettes in the Philippines was, on average, twice as high as that found in the United States or Britain.

It was probable, Dr Gray said, that this also applied to other countries in Asia and such a situation could be changed quickly by effective political action without disrupting an economy in which tobacco growing might figure prominently.

Dr Gray added it was clear health education on smoking and cancer should be introduced into school programs and that appropriate changes might be achieved more speedily in Asia than in many Western countries.

Among other obvious and accessible targets in various parts of Asia, were high smoking rates among doctors and other exemplar groups; lack of straightforward public education programs; blatant American-oriented advertising of cigarettes; lack of adequate taxation on cigarettes; and lack of restrictions on the sale of cigarettes to children.

The introduction to *Lung Cancer Prevention: Guidelines for Smoking Control*, notes that although it is more than a quarter of a century since cigarette smoking was first established as a health hazard, the problem of tobacco-associated disease had increased in many parts of the world.

Much of the increase in the problem could be attributed to the expansionary activities of the international tobacco industry; to the lack of worldwide emphasis on preventive medicine . . . and to the almost universal failure of Western societies to cope with the problems of preventing disease by means of social and political policies rather than by using pills.

The International Union Against Cancer's policy objectives are consistent with those laid down by the World Health Organization. They are:

- The achievement of lower smoking rates in all age groups by use of health warnings, taxation manipulation, restrictions on smoking opportunities, and encouragement of the rights of the non-smoker;
- The encouragement of non-smokers to remain non-smokers;
- The cessation of all forms of tobacco promotion;
- The reduction of the harmful components of tobacco smoke and the exposure of smokers to them;
- The establishment of maximum liaison between health organizations;
- The achievement of public health control of relevant industrial and environmental factors contributing to lung cancer.

The guidelines also cover public information, education, low tar, and legislation programs, and presents arguments on the economic effects of smoking.

Consultants attending the London workshop included Nigel Gray, Dr Kjell Bjartveit from Norway, Dr Lars Ramstrom from Sweden, Professor F. R. Wake from Canada, and Dr Roberto Masironi from the World Health Organization.

* **International Union Against Cancer, 3, rue du Conseil-General, 1205 Geneva, Switzerland. Tel: (022) 20 18 11.**

Bars opposed

Plans to make alcoholic drinks available in community centres in Northern Ireland have been criticized by the Council on Alcohol Related Problems in Belfast. The Council says licensing community centres would increase the carnage on Ulster's roads.

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New Books

by RON HALL

Alcohol and Young Drivers: Impact and Implications of Lowering the Drinking Age

. . . by Paul C. Whitehead

This study assesses the impact of the change in the drinking age by focusing on the collision behavior of young drivers in a single community, London, Ontario, over a period of time that includes three and one-half years prior to the change in the drinking age, and four years after the change in drinking age. This evaluation is conducted within the context of a detailed examination of the available literature on the topic and a critical assessment of the major issues involved. Implications of the findings are discussed in terms of the specific issue of traffic safety and in terms of the prevention of alcohol-related problems in general. Specific suggestions for social policy are aimed at effectively and efficiently preventing alcohol-involved collision and other forms of alcohol-related damage among young people as well as the general population.

(Non-Medical Use of Drugs Directorate, Research Bureau, Health and Welfare Canada, Ottawa, Ontario, 1977. 82p.)

Other Books

Rehabilitation Aspects Of Drug Dependence — Schecter, Arnold (ed). CRC Press, Cleveland, 1977. CRC Drug dependence series. History, etiology, international approaches, federal, state, city role, private physician, evaluation, the addict life cycle, references, index. 181p. $43.95.

Gambling And Society. Interdisciplinary Studies On The Subject Of Gambling — Eadington, W.R. (ed). Chas C. Thomas, Springfield, Illinois, 1976. Legislation, economics, sociology, psychology, mathematics, conference, Las Vegas, Nevada, 1974, references. 466p. $30.60.

The Family Guide To Good Living — Bobley, Roger (ed). Public Affairs Committee, Bohly Publishing Corp, Woodbury, NY, 1977. A practical book of often-sought advice on common personal problems; mental health, marriage, drugs, cigarettes, alcoholic teenagers, marijuana, diet, depression. 320p. $9.95.

A Hair Of The Dog: Irish Drinking And American Stereotype — Stivers, Richard. Pennsylvania State University Press, University Park, 1976. Drinking customs, Great Britain, Ireland, temperance, the Irish family, the stereotype of the Irish-American as drunkard, emigration, neighborhood, "Mommism" and "Bossism", discriminatory practices, a dialectical theory of Irish-American alcoholism, references, index. 197p. $16.25.

Science Technology And Society. A Cross-Disciplinary Perspectives — Spiegel-Rosing, Ina, Price, D. de Solla (eds). Sage, London, 1977. Essays on the social and policy developments of science published under the aegis of the International Council for Science Policy Studies. Bibliography, index. 607p. $29.95.

Drug Use Among American Women, Old And Young — Bowker, L.H.R. and E. Research Assoc, San Francisco, 1977. Sexual differentiation, rural, alcoholism, narcotic addiction, housewife, males as carriers, sociological theory, appendices, bibliography. 66p. $9.25.

A Follow-Up Study Of Clients At Selected Alcoholism Treatment Centres Funded By NIAAA — Ruggels, W. Lee. Mothershead, Ann, Pyszka, Ronald, Loebel, Maria and Lotridge, Jean. Standard Research Institute, Menlo Park, 1977. 219p. $8.

Proposal To Control Opium From The Golden Triangle And Terminate The Shan Opium Trade, Hearings — United States Congress. Committee on International Relations. US Government Printing Office, Washington, DC, 1975. Presented in April 1975 to the Subcommittee on future foreign policy, research and development. Appendix. 290p. $2.65.

Select Committee On Highway Safety: Final Report — Young F. (chairman). Queen's Printer, Toronto, 1977. Driver training, testing and licensing, the impaired driver, the enforcement system, appendices. 102p.

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six point scale. For further information, contact Linda Chung, coordinator of the group at (416) 595-6150.

Joey And Me

Subject Heading: Youth and alcohol, alcohol and family, attitudes and values.

Details: 10 minutes, 16 mm, color, sound.

Synopsis: In this animated film, a 12-year-old boy and his sister admire 17-year-old Joey. Being fatherless, with an alcoholic mother, Joey has to assume many household responsibilities. He is a star basketball player, and does not believe in smoking, drinking, or taking other drugs. He also believes he can be "his own person," and doesn't have to yield to peer pressure to take drugs. Although Joey dislikes parties where there is drinking, he feels he must attend the victory party after the basketball game in which he was the star. Unfortunately, the boy who drove Joey and his date home had been drinking heavily, and there was an accident in which Joey was killed.

General Evaluation: Very good (4.7). Contemporary, interesting, and informative film with a powerful emotional impact, and good technical quality. This film was rated an effective teaching aid, and of a suitable length for most educational uses.

Recommended Use. Likely to benefit audiences of eight years to 18 years of age.

Doing It Wrong

Subject Heading: Youth and alcohol.

Details: 28 minutes, 16 mm, color, sound.

Synopsis: Two couples plan to go camping for the weekend. Two other couples, on their way to the same campsite, steal some candy and a frisbee from a gas station. The four couples meet and share campsites. After they have finished their supply of beer, two of the boys steal beer and food from other campers. The decide later to raid cottages for more supplies. At the cottage they continue to drink, and begin to vandalize it. One of the boys attacks one of the girls, and she runs away. At the sound of an approaching car, the others flee back to their campsite, leaving the girl lost and alone. The couple who had remained at the campsite try, unsuccessfully, to persuade the group to return to look for the girl. Those who do return don't find her, and call authorities for assistance. The girl is found the next day, hurt badly, and is airlifted to a hospital.

General Evaluation: Good (4.3). A contemporary and technically well-produced film, with a suitable length for most educational uses, it was also interesting, and realistic.

Recommended Use: Likely to benefit audiences of 12 years of age and older.



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Coming Events

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Canada

A Continuing Crisis: Youth and Highs Symposium — April 11, 1978, Toronto, Ontario. Information: Canadian Addictions Foundation, 303 Kendall St, Vanier, Ont.

Detox Workers Training Program — April 24-28, 1978, Toronto, Ontario. Information: Dianne Hobbs, coordinator, Detox and Rehabilitation Programs, Addiction Research Foundation of Ontario, 33 Russell St, Tor, Ont, M5S 2S1.

Ontario Medical Association Annual Meeting — May 8-12, 1978, Toronto, Ontario. Information: Dr F.T.H. Porter, 240 St George St, Tor, Ont, M5R 2P4.

125th Annual Meeting Of The American Pharmaceutical Association — May 13-18, 1978, Montreal, Quebec. Information: ADPA, 2215 Constitution Ave NW, Washington, DC, 20037.

Canadian Lung Association Annual Meeting — June 12-14, 1978, Winnipeg, Manitoba. Information: Hubert Drouin, executive secretary, Canadian Lung Association, Suite 908, 75 Albert St, Ottawa, Ontario, K1P 5E7.

The College Of Family Physicians of Canada Annual Meeting — Sept 10-16, 1978, Charlottetown, Prince Edward Island. Information: Donald Rice, executive director, The College of Family Physicians of Canada, 4000 Leslie St, Willowdale, Ontario, M2K 2R9.

Alberta Alcoholism and Drug Abuse Commission Summer School On Alcohol and Drugs — Sept 22-23, 1978, Kananaskis, Alta. Information: Marg Bailey, AADAC Community Extension Services, 2nd floor, 812-16th Ave SW, Calgary, Alta, T2R 0T2.

13th Annual Conference Of The Canadian Addictions Foundation — Sept 24-29, 1978, Calgary, Alberta. Information: Stuart Hutton, conference manager, Action Plan '78, 812-16th Ave SW, Calgary, Alta, T2R 0T2.

The College Of Family Physicians of Canada (Ontario chapter) Annual Meeting — Oct 16-18, 1978, Toronto, Ont. Information: Marcia Barrett, 4000 Leslie St, Willowdale, Ont. M2K 2R9.

Canadian Psychiatric Association Annual Meeting — Oct 18-20, 1978, Halifax, Nova Scotia. Information: Dr A. Cote, secretary, Canadian Psychiatric Association, Suite 103, 225 Lisgar St, Ottawa, Ontario, K2P 0C6.

United States

5th National Drug Abuse Conference — April 3-8, 1978, Seattle, Washington. Information: NDAC-78, 200 Broadway, Seattle, Wash, 98122.

Odyssey Institute's Women's Workshop 11 — April 13-15, 1978, New Orleans, Louisiana. Information: A. Margaret Pike, Odyssey House, 1125 N Tonto St, New Orleans, Louis, 70119.

International Arctic Rim Conference On Alcohol Problems — April 16-20, 1978, Fairbanks, Alaska. Information: International Council on Alcohol and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

National Council On Alcoholism Annual Forum — April 27-May 3, 1978, St Louis, Missouri, Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

American Medical Society on Alcoholism — April 27-May 3, 1978, St Louis, Missouri. Information: J. G. Chen See, 733 3rd Ave, New York, 10017.

American Psychiatric Association Annual Meeting — May 8-12, 1978, Atlanta, Georgia. Information: Dr M. Sabashin, 1700 18th St NW, Washington, DC, 20009.

1978 Spring Conference Of The Wisconsin Association On Alcoholism and Other Drug Abuse Inc — May 23-25, Wausau, WI. Information: Don Johnson, conference coordinator, WAAODA, 333 W Mifflin St, Suite 4, Madison, WI, 53703.

Medical Management and Special Problems In The Treatment Of Alcoholism — May 24-25, 1978, Louisville, Kentucky. Information: Office of Continuing Education, University of Louisville School of Medicine, Health Sciences Center, PO Box 35260, Louisville Ken, 40232.

13th Annual Conference Association of Halfway House Alcoholism Programs Of North America Inc — June 4-8, 1978, Minneapolis, Minnesota. Information: Diane Fontaine-Adams, project director, Association Office, 786 E 7th St, St Paul, Minn, 55106.

The Committee On Problems Of Drug Dependence 40th Annual Scientific Meeting — June 4-6, 1978, Baltimore, Maryland. Information: Joseph V. Brady, professor of behavioral biology, The Johns Hopkins University School Of Medicine, 720 Rutland Ave, Baltimore, MD, 21205.

2nd National Youth Workers Conference — June 7-10, 1978, Washington, DC. Information: Arlene Rodenbeck, National Youth Alternatives Project, 1346 Connecticut Ave NW, Washington, DC, 20036.

Southern Oregon Institute Of Alcohol Studies — June 11-16, 1978, Salem, OR. Information: Ruthanne Lidman, SOIAS, 3355 View Drive South, Salem, OR.

American Medical Association Annual Meeting — June 17-22, 1978, St Louis, Missouri. Information: James H. Sammons, 535 N Dearborn St, Chicago, Illionois, 60610.

27th Session Of The University Of Utah School On Alcoholism And Other Drug Dependencies — June 18-23, 1978, Salt Lake City, Utah. Information: Univeristy of Utah School on Alcoholism And Other Drug Dependencies, PO Box 2604, Salt Lake City, Utah, 84110.

Annual Summer Session Of The Center For Alcohol and Addiction Studies — University of Alaska, Anchorage. Information: Carol Molinari, director, Center for Alcohol and Addiction Studies, University of Alaska, Anchorage, 3211 Providence Dr. Anchorage, Ala, 99504.

Joint Conference Of The American Association For Automotive Medicine And 7th International Association For Accident And Traffic Medicine — July 10-15, 1978, Ann Arbor, Michigan. Information: AAAM executive secretary, PO Box 222, Morton Grove, Illinois, 60053.

1978 Summer Institute On Drug Dependence — Aug 27-Sept 1, Colorado Springs, Col. Information: Summer Institute, PO Box 2172, Colorado Springs, Col, 80901.

Alcohol And Drug Problems Association Of North America Annual Meeting — Sept 24-28, 1978, Seattle, Washington. Information: Lynn Buttorff, executive assistant to director, ADPA, Suite 204, 1101 15th St NW, Washington, DC, 2005.

Association of Labor-Management Administrators and Consultants On Alcoholism Annual Meeting — Oct 4-6, 1978, Seattle, Washington. Information: ALMACA, 11800 Sunrise Valley Drive, Suite 410, Reston, Virginia, 22091.

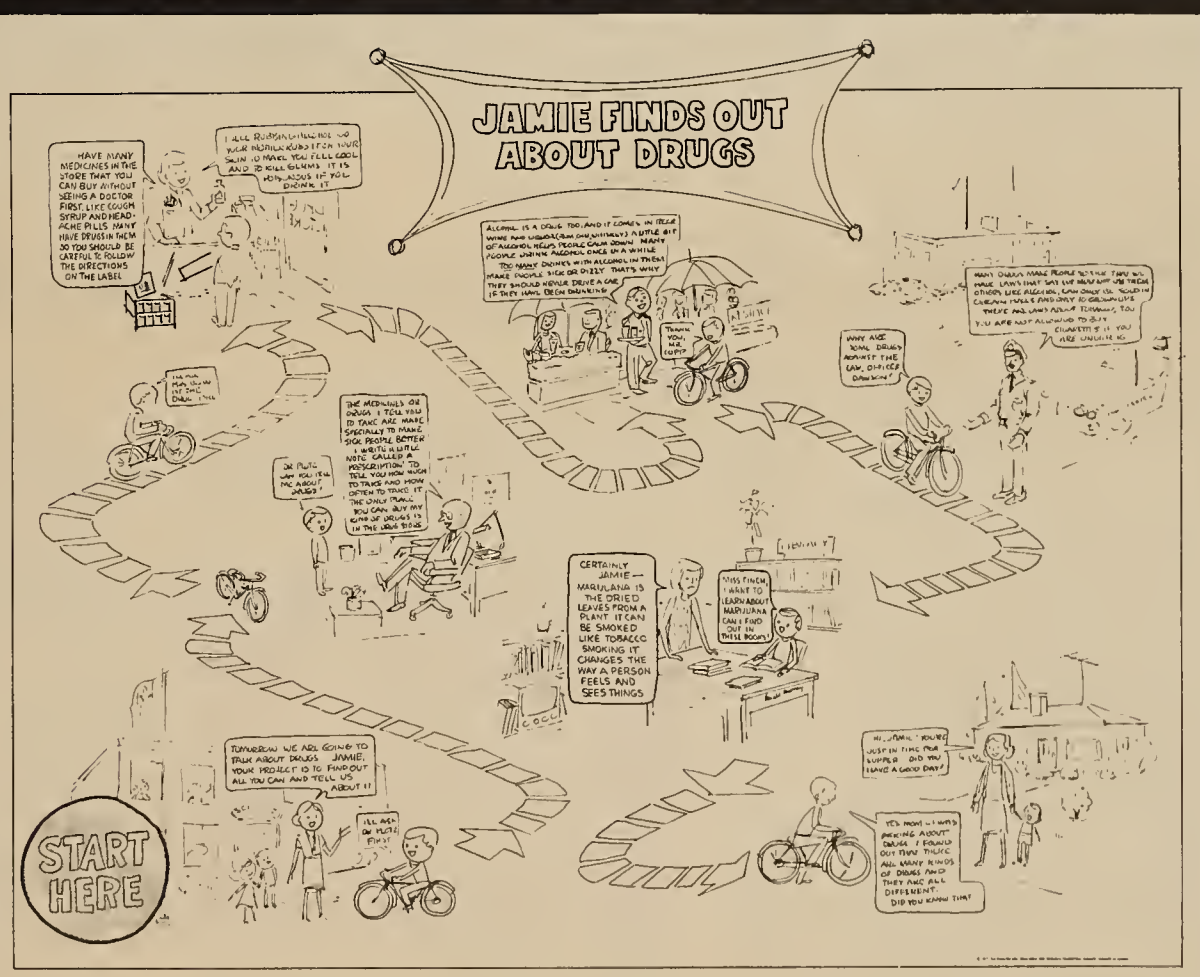
Abroad

4th International Conference On Alcoholism And Drug Dependence — May 22-26, 1978, Caracas, Venezuela. Information: International Council on Alcohol and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

8th International Institute On The Prevention And Treatment Of Drug Dependence — June 4-9, 1978, Menton, France. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

5th Institute On Drugs, Crime, And Justice in England — July 11-29, 1978, London, Eng. Information: Arnold Trebach, director, Center for the Administration of Justice, The American University, Wasington, DC, 20016.

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JAPAN





With 100,000 conveniently located beer and sake vending machines, thirsty Japanese may buy a drink 24 hours a day (top left). A young laborer drinks schochu, a cheap rice wine, at a Tokyo train station stand-up bar (left). Befuddled Japanese businessman doesn't know whether to sit cross-legged on floor or upright on subway seat (top). Photos: David Milne.

By David Milne

Alcohol 'keeps the country from exploding'

TOKYO — After his customary 10-hour day at the office, Toyoshi Suzuki dined with a client on tidbits of raw fish and warm rice wine, then rounded out the evening at a fashionable nightclub where a kimonoed hostess kept their glasses brimming with *mizuwaris* — whisky and water — until both men were quite drunk.

It was almost midnight when the good-natured hostess helped them on with their coats and loaded them into a waiting taxi so they could catch the last train home, along with dozens of other swaying and tottering Japanese businessmen.

When darkness falls and blinking neons brighten normally drab cities and towns, this evening ritual is repeated every day throughout these crowded islands.

Laborers head for streetside standbars where shoulder to shoulder they gulp down plastic cups of *shochu* — a cheap distilled spirits — dispensed from vending machines.

Look-alike salarymen — white collar workers — in dark suits with company emblems in the lapels, crowd into tiny bars — there are 10,000 in Tokyo alone — where they unwind and soothe frazzled nerves while sipping Johnny Walker at $5 a shot.

'Water-business'

Last night's drunken revellers got to work on time this morning. Suprisingly, there is no work absenteeism due to drinking. Maybe the enzyme mutation that makes Japanese flush after one drink also speeds alcohol metabolism and recovery from a hangover, according to a study by Jean Pierre Wartburg, University of Bern, Switzerland.

With expense account businessmen dropping $700-million a year entertaining clients and co-workers, the *Mizu-shobai*, meaning "water-business" entertainment, has never been better.

But the resounding shouts of *kampai* or cheers as sake cups are clinked together have taken on an ominous ring to doctors and others concerned with the burgeoning growth of alcoholism in Japan.

Problem drinkers were fast approaching two million at the last tally — close to 6% of the adult population — and similar to the United States where one in every 20 executives is labelled alcoholic.

Japan's thirst, which developed along with its gross national product, continues unabated though the economic boom has long since disappeared.

"There is no question that alcoholism is increasing in Japan," said Dr Hiroaki Kono, director of the National Institute of Alcoholism in Tokyo.

"What astonishes us is the size of the problem."

It cuts across all levels of society, according to the latest study by The Leisure Development Centre, a private research body in Tokyo, but is growing fastest in big cities and rural areas where social changes are most disruptive.

Highlighted in the study were the harmful effects of the almost mandatory drinking required of Japanese salarymen to smooth personal relationships and foster comaraderie.

THE BACK PAGE

Sixty per cent of the problem drinkers were found to be businessmen like Toyoshi Suzuki who claimed that getting drunk with clients was a part of their job and a mark of company loyalty.

An unexpected finding was that Japanese women are becoming alcoholic faster than their menfolk, although overall there are fewer women alcoholics here than in Western countries.

While Japanese women are far from liberated, more than 42% now take an occasional drink — up 18% from only eight years ago.

"Most women alcoholics are kitchen drinkers in their 30s and 40s," said Yoko Shibata, a professor of medicine at Toho University who specializes in female alcoholism.

"With husbands at work and children in school they drink out of loneliness and become addicted in six years compared to 10 years for men."

Japanese women tend to become manic depressive when they drink, which reinforces their habit.

Teenage drinking, along with teenage suicide, is also on the rise, especially among students who face cut-throat competition for entrance to overcrowded schools.

Twenty per cent of Japanese high school students said they needed a drink once a week just to keep going on the academic treadmill.

"This is very worrying to us," said Dr Kono, "because if it catches fire it would be like matches on oil."

A sociologist explained that the Japanese once restricted their drinking to Shinto festivals, such as viewing the cherry blossoms, and to the celebration of births, marriages, and other family events.

No constraint

Significant changes have taken place over the years, so that today the Japanese drink all year round without constraint.

Drinking is not a moral issue here; there is no religious prohibition against alcohol; the temperance movement has never had an impact.

Traditionally, there has been an indulgent attitude towards drunks — and for good reason.

In this tightly-knit society, where concealing emotions and frustrations is a highly developed and necessary art to maintain "consensus," getting drunk is a socially sanctioned safety valve.

"Alcohol here plays the role of psychiatry in the West," says a foreign diplomat stationed in Tokyo.

"I think the country would explode without it.

"Instead of analysis they get rid of their inhibitions with a few drinks."

At a company outing, an inebriated employee may insult his boss, lose control of his bladder, pass out on the floor, and have to be carried home by his colleagues.

Yet his behavior is not held against him, and the next day the unpleasant episode will have been entirely forgotten.

Not long ago, being drunk during commission of a crime was considered an exonerating factor.

Drunk driving was often condoned and sentences even for violent crimes committed under the influence, were frequently redueed.

The attitude today is changing and the Japanese police now see a definite correlation between alcohol and the incidence of violent crime and suicide.

Of all the murders here, approximately 37% are committed by intoxicated people.

Yet the problem of alcoholism is largely ignored by both the government and the medical profession.

Japan lags far behind most Western countries in the recognition and treatment of alcoholics.

Otherwise, how can a country of 100 million people, with a GNP behind only that of the US and Russia, and the highest literacy rate in the world, provide fewer than 800 hospital beds for alcoholic patients?

This appalling neglect is the shame of Japan's medical profession and a blot on government health organization.

Although the ministry of health and welfare mounted an investigation into the inadequate treatment of alcoholics, little progress has been made and little is expected because alcoholism does not seem to be a vital economic issue.

"The government has a complex

(See — Inner — page 12)

Drunken drivers are now ticketed and sometimes penalized by their employers. A few years ago they were often merely reprimanded for their behavior.



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The Journal

Vol. 7 No. 5 | 2nd class Mail Reg No 2776 | Published monthly by Addiction Research Foundation | TORONTO May 1, 1978

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Equal rights supporters shake drug meeting



Delegates at the National Drug Abuse Conference support a motion not to hold next year's meeting in a state which has not ratified the Equal Rights Amendment. Laura Gonzalez (above) was the mover of the motion.

Minorities threaten boycott

By Karin Pargas

SEATTLE — A commitment to human rights has left in limbo the future of the largest annual drug conference in North America.

The National Drug Abuse Conference, held here in April, was disrupted by a motion, passed four to one by delegates at one plenary session, not to hold the 1979 meeting in New Orleans, Louisiana, because that state has not ratified the Equal Rights Amendment (ERA).

(The ERA "assures equality of rights under the law shall not be denied or abridged by the United States or by a state on the basis of sex." As of Nov, 1977, 35 of 38 states required to add the amendment to the US constitution had ratified the ERA).

The framework upon which this year's conference was built crumbled slightly when delegates formed into caucuses representing various minorities. The question was whether they could honor the NDAC site selection committee's decision to hold the meeting in a state which, according to one 'third world delegate', "does not recognize or honor equal human rights for all."

Art Simmons, national chairperson for this year's conference, told delegates "we blew it." ERA ratification was not a stipulation for the 1979 bidding for the conference site, although it will be for 1980.

After many meetings with his co-chairpersons, Mr Simmons told delegates that final selection of New Orleans as next year's conference site is conditional upon that city's depositing a stipulated amount of money into a NDAC bank account within 30 days.

"And if that doesn't happen, we will go out with another request ... and a condition will be the ratification of the ERA."

Those most vocal about the need to recognize equal human rights — even at a drug abuse conference — included Clare Jones who read a prepared statement from the People's Caucus Against Racism and Sexism:

"The continuation of racism and sexism directly affects the quality of treatment and the ability of drug workers to successfully deliver services to clients. We are prepared to resist the perpetuation of bigotry by boycotting the 1979 convention."

Frank Espada was the only one of 12 co-chairpersons to support the boycott to the end. He said the 1977 NDAC conference was the first meeting opened to minorities, and prior to that "these meetings were the province of a small, elitist group ... one short year later this people's gathering is being tested again. The facts are clear, the choice is even clearer. This issue is far more important than even the survival of this conference."

Mr Espada said the caucus he represented, the National Association of Puerto Rican Drug Abuse Programs, would boycott Louisiana next year even if one million dollars were deposited in NDAC's bank account, and the ERA was not passed.

More NDAC coverage — Pages 3,4,7

Both Mr Espada and Ms Jones stressed they thought the co-chairpersons were committed to human rights: "They do as we do — what they believe is right," Mr Espada said.

Delegates and conference organizers were not alone in the ERA debate.

Plenary speaker, Senator Julian Bond of Georgia, prefaced his prepared speech by telling delegates he hoped the boycott would succeed: "I will remind you it took boycotts and other kinds of actions which hurt some people bad enough to force many of these states to pass (the ERA) in the south."

Not all agreed with the boycott.

Co-chairperson Ramon Adame, who told delegates he had pressed for many years for NDAC to represent minorities, condemned the boycott, saying it would only lead to "going back to the beginning again."

Mr Adame, who calls himself the "biggest Chicano ex-addict" in the US (**The Journal**, January), said the large minority representation at the San Francisco conference in 1977 came about through pressure. But "it is impossible to include everybody. Now, one year later, the people we were fighting for, are fighting us. Crucify us for trying to bring the conference to the people."

And, despite the fact the majority of delegates were pressing for a new conference site, most applauded one participant who wanted "to get back to the business of treating people, and stop politicking."

Alcohol and pot disturbing military

OTTAWA — Marijuana use, especially by young recruits, is increasing as a problem for Canada's military.

Lt-Gen J. C. Smith, assistant deputy defence minister, added in testimony before the House of Commons defence committee that alcohol abuse in the armed forces is a much more serious problem.

And while marijuana use seems to be on the increase, there is no hard evidence that more potent drugs such as heroin, cocaine, and LSD are a significant abuse problem in the military in Canada.

The armed forces tries to minimize the drug problem starting at the recruitment stage, where potential candidates for the military are counselled about the attitude of the military towards drug use.

Rehabilitation programs have already been established for alcoholics in the military at several locations across Canada. And first-time offenders caught using marijuana are normally required to take special counselling.

The military cracks down hard only when faced with persistent marijuana use or a more serious problem such as drug trafficking. Then the penalty can include a military court martial.

Lt-Gen Smith observed that "there tends to be a correlation between the very new recruits just out of high school and the incidence of marijuana use."

Robert DuPont, NIDA director

Paraquat risks 'simply unknown'

By Karin Pargas

SEATTLE — Potential health hazards associated with smoking marijuana contaminated with the herbicide Paraquat "are simply unknown at this time," according to Robert DuPont, director of the National Institute on Drug Abuse in the United States.



Robert DuPont

"There has been an over-reaction and under-reaction to the Paraquat issue," he told **The Journal** at the National Drug Abuse Conference here, "and I deal with the issue with some trepidation."

Dr DuPont's "hunch" as a physician, and his experience during the last few weeks with the emergence of Paraquat as an issue, is that "it is very unlikely that anyone would suffer from an acute syndrome associated with Paraquat poisoning from the use of marijuana.

"The dosage levels that people are exposed to are sufficiently low in terms of the toxic effect. The likely toxicity would be chronic rather than acute."

He said it would be unlikely for those who have smoked Paraquat-contaminated marijuana to have immediate symptoms, such as fever, coughing up blood, pain in the chest, and headache.

"Much more likely, there would be a chronic reduction in respiratory capacity, and a shortness of breath over the course of months or years," Dr DuPont added.

"What's happening now is that everybody that smokes marijuana who has a headache, upset stomach, or develops pneumonia, feels convinced that it's caused by Paraquat.

"We've been accused of trying to scare people off the use of marijuana by exaggerating the health effects of Paraquat and at the same time, we've been accused of not being strong enough in our statements about this dangerous contaminant."

He said NIDA has now arranged with the Center for Disease Control in Atlanta, Georgia, to refer all suspected Paraquat poisonings there.

Dr DuPont said concern about Paraquat has led to the assumption by many people, that marijuana itself is free of toxicity: "Of course this is not the case, particularly when it comes to lung function.

"Marijuana is regularly associated with bronchitis, cough, and reduced respiratory capacity, Paraquat or no, so it has become a very complex issue to sort out," he concluded.



The decade in review — See The Back Page

Inside

- *Wayne Howell* 2
- *Inside Science* 8
- *Letters to Editor* 9
- *Around the World* 10
- *Factsheet* 13
- *New Books* 14
- *Coming Events* 15

Search warrants under tighter control in Canada

By Bryne Carruthers

OTTAWA — The federal government has decided to continue issuing controversial "writs of assistance" to the RCMP who are enforcing the Narcotic Control Act and the Food and Drug Act, even though writs issued under the Customs and Excise Act will be abolished.



Ron Basford

However, in future, the writs allowing specified RCMP drug squad members to break into and search private property (where they suspect illicit drugs might be found) without the normally-required search warrants, will be subject to considerably more control.

Perhaps the most significant change will be the granting to judges of full discretion as to whether they should or should not issue writs of assistance to particular RCMP officers in particular circumstances.

Previously, judges had to issue writs when requested by the appropriate federal minister (in drug cases, the minister used to be the health minister, but this power has already been transferred to the justice minister) **(The Journal,** April).

The controversy over writs first surfaced when a federal court justice complained in 1977 about this lack of judicial discretion.

Another important change is that police officers using a writ of assistance must report to the issuing court, to justify each use of the writ.

According to a statement issued by Justice Minister Ron Basford, this latter requirement is similar to one in the recently-enacted gun control measures and "will ensure that the continuance of writs of assistance under drug legislation serves the best interests of justice in Canada."

(A typographical error in the statement had capitalized the word "justice," giving the appearance that the measure was designed to serve the best interests of the Justice department in Canada.)

Other changes, which like the rest must await passage of enabling legislation, include limiting the validity of writs to an as yet unspecified period of time and requiring that the RCMP officers to receive the drug writs have had at least two years of experience in the RCMP, including at least six months in the drug squad.

In the interim, until the enabling legislation is approved by parliament, Mr Basford says a series of strict administrative controls will be immediately implemented, to match as closely as possible those planned under amendments to the two drug acts.

The RCMP, the only police force allowed to have such writs, have also instituted what is described as a "careful and ongoing monitoring of the use of existing writs of assistance."

It is not clear whether already-issued writs, which have no time limit and which are issued to specific officers, will be subject to the same requirements and restrictions as new writs issued after the appropriate legislation is approved by parliament.

The announcement of changes in the handling of writs of assistance follows a governmental review that took place during a one-year experimental freeze on issuance of new writs.

In attempting to balance "the collective public interest in the enforcement of the laws of Canada against the essential freedom of the individual from unreasonable search and seizure," the government has concluded that the enforcement of the Narcotic Control Act and the Food and Drug Act "does require the existence and utilization by the RCMP Police of writs of assistance," according to Mr Basford.

"One of the primary difficulties in effectively policing illicit possession and trafficking in drugs is the pervasive influence of organized crime.

"That influence, plus the covert nature and ease of transportation and disposal of illicit drugs, requires extraordinary measures to efficiently and effectively enforce the Narcotics Control Act and the Food and Drug Act.

"This, when coupled with the difficulty of obtaining search warrants on very short notice, justifies, in the government's view, retention of special search powers," the Justice Minister observed.

Home brew laws broadened

WASHINGTON — The quiet hubble-bubble of beer fermenting away in many United States homes soon will become a legal sound. And unmarried people will be able to make wine.

Both have been illegal until now.

The House of Representatives has passed, and sent to the Senate, a measure which will legalize home beer making, and alter some of the provisions for home wine making.

One of the provisos is that the amateur brewer registers with the treasury department.

Until now, wine-making at home has been confined to the person qualifying as the head of a family. He, or she, could make up to 200 gallons a year, but single people were barred from doing so.

The new measure will allow homes with two or more people over the age of 18, and married or not, to produce up to 200 gallons of wine or beer a year tax free.

There are no changes for moonshiners. The toil and trouble of distilling corn liquor in secret will continue, as they try to avoid federal revenue agents.



Beer and wine making at home will become legal soon in the United States. But the law will still keep moonshiners in the woods.

Manitoba cuts back budget for alcohol

WINNIPEG — Health Minister L. R. (Bud) Sherman of Manitoba has confirmed that government funding for the Alcoholism Foundation of Manitoba will be cut this year from last year's $4.6 million, but has so far declined to say by how much.

"We hope they will tighten up on administration costs, while preserving the field service," Mr Sherman said in an interview after tabling the foundation's annual report for last year in the Manitoba legislature.

He said the task force on government reorganization had raised questions about top-heavy administration in the AFM. On the other hand, the minister praised the foundation's field service.

Foundation chairman R. S. Graham said expansion will have to be abandoned for the coming 12 months, but the treatment program will be maintained at its present level.

"We're going to try to keep the same level of service, but we'll have to operate with a hell of a lot less money."

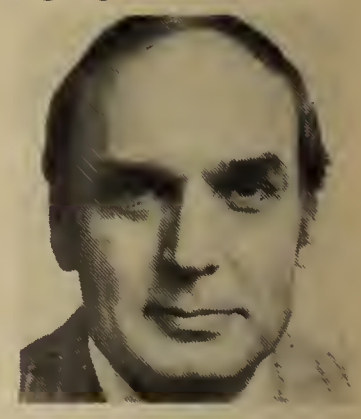
Mr Graham declined to say what the reductions would be. The foundation had asked the government for $5.2 million for this year.

In the annual report, Mr Graham said the foundation "will attempt by every possible means to cut back without entirely eliminating programs which have the least impact on direct service treatment systems. When the fiscal climate improves, such programs can again be restored to full operation."

The chairman said the agency will retain its 144-member workforce throughout the province, but training programs and resource material will have to be reduced.

"We will eliminate everything possible without reducing treatment service on either an in-patient or out-patient basis."

The now-abandoned expansion plan for the next 12 months would have included new out-patient clinics in Beausejour, Dauphin, and Portage la Prairie, a Winnipeg settlement house for natives in conflict with the law, which the federal government was going to co-finance.



L. R. (Bud) Sherman

Pinball wizard Howell on the road to recovery

By Wayne Howell



According to David McKearnin, a graduate psychology student at McGill University, the recent proliferation of penny arcades in our major cities has the potential of turning some individuals into pinball addicts.

Don't I know it. Not too long ago, a funny thing happened to me on my way to my noon-hour swim, I got hooked on, Sea Wolf, a stupid electronic game that gobbles quarters (penny arcade is a misnomer) the way the cookie monster gobbles cookies.

My first reaction was: how could this happen to me? I was not the kind of introverted loner described by Mr McKearnin as a person at risk. How then, did I end up in the Holiday Inn games room feeding quarters into Sea Wolf, cheek to jowl with a rag-tag band of teenagers involved in similar pursuits?

When I look back on it, I can see that my first mistake was to succumb to the siren call of the arcade, the metallic dings and dongs of the pinball machines, and the space-age blips and bleeps of the electronic games. There was something about the exotic cacophony that piqued my curiosity. I stepped into the room.

I can see now that my second mistake was to have been carrying a quarter in my pocket at the time. For you can't go into a penny arcade just to "look around." Sooner or later you will want to give it a go. Not so badly that you will take the trouble to break a bill. But if there is a quarter in your pocket, the urge to feed it into a machine any machine, soon becomes inexorable.

My third mistake was to put my quarter into Sea Wolf. In retrospect I can see this was a very poor choice, but I was an innocent at the time. Before I knew what was happening to me, I was hooked.

In spite of my own misfortune, I don't think prohibition is the answer: the players would just be driven underground and people who could ill afford it would be shelling out hard-earned dollars for electronic gizmos to mount on television sets in the privacy of their own homes. And I do think it's possible to use and enjoy these games in moderation if one is prudent and follows a few common sense rules:

1) Play a game that involves an opponent. These games, such as electronic ping-pong games, are relatively innocuous since you lose to a person and are not left with vague feelings of inadequacy because you have been bested by a bunch of tubes and transistors. (Sea Wolf involved shooting little electronic torpedoes at ships moving across a screen. It was me against the machine and when I lost I felt the same way I feel when a Coke machine takes my money but doesn't deliver the goods: I want revenge.)

2) Play a game that promises absolutely nothing. If the game makes no promises you will soon tire of racking up points for no good purpose. (Sea Wolf promised that if I sunk enough PT boats, destroyers, and freighters in the allotted time, I would get a free replay; tantalized by this possibility, I quickly slid into a two quarter a day habit.)

3) Play a game that requires a minimum amount of skill and/or strategy. The less mental energy necessary, the less likely you are to get hooked. (Sea Wolf was actually challenging, and in my spare moments I would find myself contemplating the virtues of firing single torpedoes versus 'bracketing' a vessel or mentally calculating the lead I would take on my next PT boat. I lived a double life: on the surface a normal responsible citizen — underneath the veneer, a mad U Boat Commander.)

The story of my recovery is not worth recounting in great detail. I was one of the fortunate ones who actually achieved replay after a relatively short period of time. Now I can take Sea Wolf or leave it. Just the other day — when the idea of this confessional column hit me — I went back for a nostalgic fling. Just one go-round to prove that I could achieve replay once again. For old time's sake. Just one game. And that was how I learned the fourth common sense rule:

4) Don't go back for just one game with three quarters in your pocket.

(Wayne Howell is an Ottawa physician and freelance writer.)

US must rethink drug policy: Bryant



Tom Bryant, chairmen US commission on mental health.

By Karin Pargas

SEATTLE — Demand for drugs in the United States can only be reduced by addressing the issues that lead people to use them.

"So long as poverty, discrimination, and unequal opportunity continue to exist in our country, the demand for addiction will continue," according to Tom Bryant, chairman of President Jimmy Carter's commission on mental health.

"We continue to act as though drugs themselves are the real problem. We spend billions of dollars in our efforts to keep illicit drugs out of this country, and out of the hands of those who wish or need to use them.

"That dichotomy should be discarded in favor of a consistent approach to the use and misuse of all psychoactive substances, including alcohol and nicotine. It is the height of national folly to issue moralistic calls for abstinence from some drugs while we sit around pouring drink after drink and promoting 'happy hours'," Dr Bryant told the National Drug Abuse Conference here.

He said the concept of non-addictive, non-destructive use of heroin is a "startling new development" which contravenes the cornerstone of what has been national anti-heroin policy and the efforts aimed at eliminating that drug.

"If further research confirms the precise nature and extent of non-addictive heroin use, a reassessment of our prohibitionist policies would be in order."

For those who need treatment for their heroin addiction, he added, it is time to examine the relationship between drug abuse treatment and the criminal justice system.

Dr Bryant said the growing, close relationship between the criminal justice system and diversion programs which bring drug dependent people who have broken the law into treatment, has been brought about by the belief illicit drug use invariably causes crime.

"What, in fact, is the link between drugs and crime? We don't really know despite all the claims of its existence.

"We do have evidence that many individuals who commit crimes use drugs, and it is likely that some, perhaps many, addicts commit crimes to support their daily habit. Despite the absence of any firm answers about the drug-crime relationship, this continues to be one of the most potent political issues in this country, striking at the fears and prejudices of us all."

Dr Bryant said the public has been persuaded "get-tough" drug laws would reduce addiction and crime. But the approach has not worked, has not reduced drug and crime behavior significantly where it has been tried, "nor did it reduce other social costs of drug abuse after a substantial investment of money, resources, and rhetoric."

He contrasted the hard-line approach to heroin use with results of cannabis decriminalization in 10 states in the US: "Critics predicted an explosion of marijuana use, a prediction rooted in the view that it is the law that restrains people from illicit drug use."

However, a survey conducted in Oregon, the first state to decriminalize marijuana, showed little change in marijuana use patterns: "What this experience shows us is just how little the criminal law influences a person's decision to use a particular drug."

Dr Bryant concluded: "Past drug policies continue to be present drug policies, and unless we rethink our subject in the light of new knowledge, our future drug policies will continue to be those of the past."

Skin color is the important factor

Social ills cause drug abuse

SEATTLE — Society's abuse of the "under class" in the United States is the reason for the dramatic proportion of non-white, drug dependent people living in the country today.

In an emotional speech to delegates at the National Drug Abuse Conference here, Senator Julian Bond of Georgia, a black political activist, said social ills including drug dependence are "the" problem of the 20th century.

"You know more about the subject of drug dependence than I will ever hope to know. But the problem of the 'color-line' stands behind this one (drug dependence), and indeed, behind nearly every other problem American citizens of every race, color, and sex face too.

"It is the reason why 65% of reported opiate abusers are non-white. It is the reason why 90% of clients getting a cure at the state level are white, and the reason why your clients will always increase in direct proportion to the problems of the perennial victims of all sorts, particularly victims of abuse at society's hands.

"So many civilized people are willing to live in comfort, even when the price of this is poverty, disease, and ignorance of their fellow men."

Senator Bond attacked his fellow Democrat President Jimmy Carter and his concessions to balanced budgets at the price of the health care and adequate income of the American "underclass".

"If this is, in fact, a government as good as its people, then either the people, or the government, or both, are stingy, mean-spirited, and greedy. Given a choice between spending more and taxing less, Carter and company have chosen the latter, with dire consequences for those who hope for some assistance to solve the great human problems of our time.

"Even the debate about the three-martini lunch has been resolved against the taxpayer, who will continue to subsidize a daily martini-and-a-half."

Senator Bond said the concessions to equal rights for blacks, after the uprisings, revolts, and bloodshed of the 1960s in the US has accomplished too little: "The right to sit in the front of a bus may lose meaning for people whose longest trip is from the feudal system of the rural south to the more mechanized high-rise poverty of the north.

"The right to eat at a lunch counter means little for people with champagne appetites."

Elderly drug misuse is 'totally ignored' in US

SEATTLE — Drug programs in the United States are ignoring the drug misuse of millions of people — the elderly.

"Studies are beginning to show there is a great deal of unintentional misuse of medicine by the public, especially among the elderly who are the largest majority of drug users," Ron Gaetano, co-chairperson of the National Aging Task Force said here at the National Drug Abuse Conference.

"I think the time has come for drug abuse professionals to deal with a larger target population rather than the small minority who abuse the 'bad drugs'."

Mr Gaetano said the elderly population is one example of a group totally ignored. Yet, the over-65 age group accounts for 10% of the population in the US, and consumes 25% of all the drugs taken in the county.

"If those of us in drug abuse programs begin to educate people regarding how medicine can help them, as well as injure them, we will find ourselves closer to dealing with the country's drug problems," he added.

He said people over the age of 65 incur the greatest risk of drug reactions, yet too little money and energy are spent to aid these individuals.

Quoting national statistics, Mr Gaetano said the American public consumes nearly 40 billion doses of medication each year, and the average doctor writes 8,000 prescriptions each year.

"Many of these medications are needed. The individual who needs these medicines brings to his drug scene the same thing the person who abuses drugs brings: that is almost total ignorance of the medication, and very little awareness of their own variables which will affect the way the medication works."

Mr Gaetano said the body doesn't differentiate between "legal medication" and "illegal drugs," nor does it consider whether a chemical is a prescription drug or an over-the-counter medication: "Any chemical that a person uses brings to that person some benefits and risks.

"People are going to be taking medicine from their early years to their final days. Ignorance is one of the enemies that must be dealt with if we are going to win the battle of drug abuse," he concluded.

More power given to FDA in Carter's drug law overhaul

WASHINGTON — Major revisions in drug laws which will give more power to the Food and Drug Administration have been introduced in the United States Congress.

The proposals drawn up by President Jimmy Carter's administration are the most comprehensive overhaul of the drug laws since 1938.

Two provisions would answer much of the present criticism of the FDA's machinery: the time it takes to get a new drug on the market, and the time it takes to take a dangerous drug off the market.

Research steps that can be shortened without compromising safety are created for valuable drugs to reach the market more quickly. This would be for drugs considered "breakthroughs" in treating life-threatening, or severely debilitating, illness or injury.

In turn, the FDA would have power to withdraw dangerous drugs more quickly than at present. Some of the lengthy hearing procedures would be bypassed.

In another major change, pharmaceutical companies would be responsible for monitoring the side effects of drugs even after they go on the market.

The most controversial proposal, which the pharmaceutical industry has said it will fight, is a requirement to make public the experimental data on the safety and effectiveness of a drug.

The industry claims this will force them to register new drugs abroad before registering them in the US because of fears such public disclosure will lead to pirating of their research data by competing companies.

Patients will be given more information about the drug they are prescribed, and about the possible risks and side effects. Another change would ban drug companies from giving away free samples to doctors.

Lengthy hearings in both the Senate and House of Representatives will be held on the bill.

9-year-olds sell cannabis

WILLIMANTIC, CN — Six nine-year-olds are among 54 young people who have been arrested in this small town for the possession or selling of marijuana.

One of the nine-year-olds is charged with both possession and selling of the drug.

The arrests followed a six-month police investigation launched after a request for action by a number of parents in the town.

NIAAA assists states

SEATTLE — Alcohol problems can best be controlled at the state level, according to Ernest Noble, director of the United States National Institute on Alcoholism and Alcohol Abuse.



Ernest Noble

He told the National Drug Abuse Conference here: "The states have the funding base, the legislative options, and continuity of programming. Because of these inherent advantages, the weight of federal dollar support must go to the states."

Dr Noble said NIAAA's attention to state programs would not exclude voluntary organizations as "they are still the heart and soul of the movement to control alcohol problems."

NIAAA has awarded 19 grants recently to help state level organizations promote the growth of volunteer activity in occupational programs, crisis intervention work, out-patient and in-patient clinics, and programs for women, youth, and minorities.

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US national drug surveys

High schoolers favor 1) tobacco 2) pot 3) alcohol

SEATTLE — Two national surveys of drug use released here by the National Institute on Drug Abuse show a rise in the use of marijuana, cocaine, and phencyclidine (PCP) in 1977. The use of other drugs remained relatively stable.

The *National Survey on Drug Use: 1977*, is based on a nationwide household sample of 4,594 people, and *Drug Use Among American High School Students*, on 18,436 high school seniors in 124 schools. The major findings are:

- Drugs used most often by high school seniors on a daily basis are tobacco (29%), marijuana (9%), and alcohol (6%). Of these, only daily marijuana use has increased — from 6% in 1975 and 8% in 1976.
- Although the percentage of youths who have tried an illicit drug is 62%, an increase of 3% since 1976, 42% of this use can be traced to experimentation with marijuana.

Marijuana

- 56% of high school seniors report having used marijuana at least once in their lives, an increase of almost 10% since 1975, 35% having used it in the last month, 9% using it daily.
- High school seniors expecting to complete four years of college have a lower rate of marijuana use (43%) than those not expecting to go to college (51%).
- Marijuana use occurs more often in large cities (53%) than in non-metropolitan areas (41%), although no regional differences were seen.
- The percentage of 12- to 17-year-olds who have used marijuana rose by 6% in 1977, for 18- to 25-year-olds, it rose 7%, and for 26- to 34-year-olds, it increased 8%.
- One in four young adults (18 to 25) have used marijuana in the past month.
- Less than half of those between the ages of 12 and 25 believe marijuana is addictive, while close to two-thirds of those older than 25 believe it is addictive.

Stimulants

- Next to marijuana, stimulants are the most widely used illicit drug by high school seniors, with 23% having experimented, and 9% current users.
- 21% of 18- to 25-year-olds have used stimulants, a rise of 5% since 1976.
- Use of stimulants has remained stable with one in 20 youths and one in 12 older adults reporting use.

Cocaine

- The greatest use of cocaine is among 18- to 25-year-olds. 19% of this group (up from 13% in 1976) has used cocaine, and 4% in the past month (an increase of 2% since 1976).
- 11% of high school seniors have tried cocaine, 3% are current users.
- The percentage of high school seniors who think there is a great risk in trying cocaine dropped from 43% in 1975 to 36% in 1977.
- Cocaine's use by seniors is more prevalent in cities than in rural areas.

Hallucinogens

- For both youths and adults, use has remained relatively unchanged since 1976.
- Experience is reported by 5% of 12- to 17-year-olds, and by 6% of those older than 18.
- 14% of high school seniors have tried hallucinogens, a drop of 2% since 1975.
- Use of hallucinogens by high school seniors is more prevalent in urban areas.

PCP

- PCP use rose 3% (from 3% in 1976 to 6% in 1977) among 12- to 17-year olds, and 4% (from 10% in 1976 to 14% in 1977) among 18- to 25-year-olds.

Inhalants

- Use has remained stable since 1974 with 9% of the 12- to 17-year-old age group, 11% of the high school seniors, and 4% of those 18 and older having used inhalants. Nearly half of those who have used inhalants, have only experimented once or twice.

Heroin and other Opiates

- Use has remained stable since 1976 with 1% of youth and 1% of adults reporting experiences.
- Of 12- to 25-year-olds, half indicated they had tried heroin only once or twice.
- 2% of high school seniors have tried heroin at least once in their lives.
- A decrease in the belief that heroin is addictive was seen in all age groups (86% in 1976 to 78% in 1977).

Sedatives

- 18% of 18- to 25-year-olds (6% more than in 1976) report non-medical experience with sedatives compared with 3% of 12- to 17-year-olds and 3% of adults older than 26.
- 5% of high school seniors reported current use of sedatives while 17% reported having used them at least one.

Tranquillizers

- An increase of 4% (from 9% in 1976 to 13% in 1977) was seen in the non-medical use of tranquillizers by 18- to 25-year-olds.
- Other age groups remained stable with 12- to 17-year-olds reporting 4% use, and adults 26 and older reporting 3%.
- 18% of high school seniors reported they had used tranquillizers, and 5% reported current use.

New Mexico wants pot for medical research

WASHINGTON — New Mexico state medical officials have applied to the relevant federal agencies here for approval to carry out research with marijuana on selected patients suffering from glaucoma or nausea induced by cancer chemotherapy.

The research will be funded by the state. It has been authorized in a bill passed by the state legislature.

The state lawmakers responded to the appeals of a young resident receiving cancer chemotherapy. He had only limited access to getting marijuana, which has proven to be the only drug to control his nausea.

New Mexico officials have asked the Food and Drug Administration for an investigation of new drug certificates, and the National Institute on Drug Abuse for legal marijuana supplies.

They have also been in contact with the National Cancer Institute.

A medical supervisory board composed of an oncologist, opthamologist, and another doctor will select both the doctors and the patients who will be allowed to take part in the research. The board will operate under the state bureau of hospitals and institutions.

An official at NIDA who is advising the New Mexico officials, told **The Journal:** "It is encouraging the state legislature has been so responsible. We think it is very good the research will be funded by the state."

Several other state legislative committees are considering laws similar to that enacted in New Mexico.

The NIDA official said one reservation is that "the FDA might get concerned after a while about how many of these studies are carried out.

"The whole idea of this kind of research is to expose as few people as possible to learn the answers to the questions."

Two cannabis derivatives rescheduled

WASHINGTON — Two cannabis derivatives, delta-9-tetrahydrocannabinol and cannabidiol, have been rescheduled for research purposes by the controlled substance advisory committee of the United States Food and Drug Administration.

The two derivatives have been moved to Schedule 2 from Schedule 1. This schedule classifies a drug as having abuse potential but also therapeutic benefits.

The committee rejected an earlier motion by David Smith of San Francisco (medical director, Haight-Ashbury Free Medical Clinic), that cannabis and all its derivatives be rescheduled. It also rejected any move to allow it to be prescribed by doctors.

The committee adopted Dr Smith's compromise that delta-9-THC and cannabidiol be rescheduled. Dr Smith told **The Journal**: "This decision acknowledges that cannabis has accepted therapeutic use."

Until now, the Schedule 1 classification has inhibited research "by a lot of investigators, particularly non-psychopharmacological ones, who shied away from research on a Schedule 1 drug because there were so many hassles associated with it," he said.

The committee decision still must be approved by the FDA administrator, the department of health, education and welfare, and the DEA. No past decision of the committee has ever been rejected.

Joint meets for ADPA/NDAC?

WASHINGTON — A proposal to "co-locate" the annual meetings of the Alcohol and Drug Problems Association and the National Drug Abuse Conference is now under consideration.

Lynn Buttorff, assistant to the director of ADPA, told **The Journal**: "In no way should this be considered a move to combine the organizations, or for one to take over the meetings, or anything else.

"What we are talking about is co-location of the 1979 conference."

Impetus was given to the idea of a joint meeting after Seattle was chosen as the site for the NDAC meeting in April, and the ADPA meeting in September.

Prospects for a joint 1979 conference are now being considered by a 15-member committee: seven from NDAC, seven from ADPA, and a 15th member agreed upon mutually.

Mr Buttorff says the 15-member committee will look at the separate programs, find areas of overlap, and try to coordinate efforts. A major idea is concurrent plenary sessions.

Current legal BAL is ridiculous: MD

WINNIPEG — People convicted of drunken driving should lose their licences for life and on conviction of their first offence, says William Davidson, a Winnipeg psychiatrist.

Addressing a meeting of The Salvation Army here, Dr Davidson said: "The current 0.08% acceptable blood alcohol level is ridiculous."

He said there is no such thing as a safe blood alcohol level. "An ounce of liquor is enough to impair you."

The law should allow no permissible blood alcohol level and, if apprehended, offenders should lose their drivers licences for life, the psychiatrist said.

Canadians are faced with the danger of alcoholism because it is profitable and socially acceptable. The provincial government in Manitoba, for example, received $57 million and the federal government $200 million from taxes on alcoholic beverages last year alone, Dr Davidson said.

"The government sells it. The government is the pusher," he said.

Revenue from the sale of liquor should be used for solving problems caused by drinking, Dr Davidson said.

"In my opinion, in Canada today people are assaulted with alcohol problems of crisis proportions," he said in an interview.

"Governments don't make a profit in the long run when you consider the cost of hospitals and social services needed because of drinking.

Beer for art's sake

LONDON — Many British beer lovers through small donations are helping the Tate Gallery here in its bid to keep Thomas Gainsborough's portrait of beer baron Sir Benjamin Truman from going to America.

Paul Mellon, the American art collector, bought the portrait recently. Under British law, however, it has to be kept in the country if the offer of $780,000 is matched.

The Tate Gallery has collected so far $560,000, and much of the money has come from beer drinkers. Sir Benjamin's portrait appears on the label of Truman's beers.

Alcoholic families shouldn't cover up

LONDON — A plea for families of alcoholics not to cover up the problem has been made by Marie-Louise Meyer, director of the London Council on Alcoholism.

Miss Meyer, a State Registered Nurse, says in a new booklet *Counselling Families of Alcoholics** that the "hush-hush" approach by families to the problem was still so prevalent in the United Kingdom that the majority of alcoholics were not seeking the help they needed.

Many wives were guilty of false loyalty in refusing to believe their husbands could be alcoholics. Until the later stages of alcoholism, the problem was hidden by family, friends, and employers.

One of the major reasons for the approach was that the alcoholism stigma still persisted even leading to a family's making a complete withdrawal from society.

Children were afraid to invite friends home because they did not know how their father would behave and wives dropped their hobbies and outside interests until they were left only with the alcoholism problem.

Dr Gloria Litman, clinical psychologist at the Addiction Research Unit, Institute of Psychiatry, London, says the objective of Miss Meyer's booklet is to give guidelines to the helping professions.

*** 68, Chalton-St, London, NW1, telephone 01-387-2191.**

'Operation Julie' smashes world LSD supply

LONDON — The supply of LSD throughout Europe and to some extent to North America is believed to have been substantially reduced thanks to the smashing of a remarkable drug syndicate by British police.

With the arrest and sentencing of 17 individuals at Bristol Crown Court, in fact, some estimates have put the output of their two illicit LSD "factories" as responsible for 60% of the world's total supply.

The police operation — named Operation Julie after one of the young policewomen involved — got into gear early in 1976 after Home Office scientists working at Aldermaston, Berkshire, discovered that samples of LSD captured in widely removed parts of the world had, or appeared to have, a single British source.

Ultimately, the police uncovered two super-factories, one in rural Wales and the other in central London. The factories had brought in for the conspirators such vast sums of money that they had difficulty deciding what to do with it.

Key figures in the drug ring were a brilliant chemist, Richard Kemp, who operated the Welsh manufacturing operations and his mistress, Dr Christine Bott. Both firmly believed that by providing large quantities of pure LSD for the illicit market, they were doing the world a good turn.

'A walking encyclopedia of the drug culture . . .'

Kemp and Bott were jailed for 13 years and nine years respectively — part of a total of 120 years in jail for the 17 conspirators.

As the police investigation of the LSD source got into gear, it was found that both the London and Wales operations were the work of highly-educated "professional" university graduates with considerable organizational flair.

But the catalyst was American author David Solomon, 52, said to be "a walking encyclopedia of the drug culture" who lived with his family in the county of Cambridgeshire.

It is believed it was when Solomon, a long-time friend of Timothy Leary, met the chemist Kemp and found that he shared his belief in the virtues of LSD, that the idea of mass producing the drug was born.

For the police, Operation Julie meant their posing as hippies in a cold and damp mountain cottage in Wales and in a north London semi-detached house.

After months of surveillance, a wave of police raids in March 1977 involved entering no fewer than 87 different premises in England, Wales, and Scotland.

Later, Leslie Pearce, assistant chief constable of Avon and Somerset, who masterminded Operation Julie, said: "We had hoped for 90% success and had 500%. This chapter in police history will stand beside the Spaghetti House and Balcombe Street sieges" (two highly successfully operations against London gangs responsible for Irish Republican Army bomb attacks).

At the Bristol Crown Court hearing, Mr Justice Park, the judge, said Kemp, 34, had avidly read all the literature on LSD and become a world expert. He was able to devise a new process which resulted in an extremely pure product.

"All this was done, it is said, in pursuit of the ideal that LSD liberated people's minds and, therefore, would be beneficial to mankind," the judge said.

Accused's 'talent' was wasted in LSD production . . .

"That was, I think, a false ideal."

He told Kemp: "Your considerable talent, which over the years could have been of such benefit to society, has in my judgment been wasted in the production of LSD."

On the distribution network built up by Kemp, Bott, and the London factory operators, the judge said: "Distribution on such a gigantic scale must have reached people of all ages from school children upwards; people with different degrees of responsibility such as those who would drop a tablet into a glass of beer as a joke.

"No doubt, there are many people who are able to take the drug without causing harm to themselves and without causing harm to other people — on the other hand there must be countless people who are not."

The longest sentences, of 13 years, were passed on Kemp who headed the group operating in Wales, and Henry Barclay Todd, 32, the head of the London factory.

Both had pleaded guilty of conspiring to possess LSD between 1970 and 1973 and to aiding and abetting the possession of LSD by others.

Family therapy for physicians

Impaired MDs' lifestyles perpetuate symptoms

By David Milne

SAN FRANCISCO — Family therapy is especially useful for treatment of impaired physicians, because of the way their families are organized.

In many ways the impaired physician's family can perpetuate his symptoms, so it is vital to treat the entire family to get at the root of the problem, according to Elaine Knutsen. Dr Knutsen is co-chairperson of the California Psychiatric Association's committee on professional health and practice, and a staff member of Napa State Hospital, Imola, CA.

Impaired doctors are often found in families that operate under strict ground rules designed to perpetuate maladjustment.

An understanding of how such families are organized, and of their rules, can be utilized by the therapist in treating its members, Dr Knutsen said at the California Medical Association meeting here.

One type of family lifestyle, paradoxically dubbed "the children come first," is characterized by making great sacrifices for "the children". "The children" could also mean the physician's patients.

For the administrator of a hospital or a ward, the staff may become the children.

The overall philosophy is that, regardless of the consequences or the appropriateness of an action, the children come first and others tend to be deprived emotionally, said Dr Knutsen.

With this type of family lifestyle comes a series of rules: don't let on that you want anything for yourself, don't be wrong, and don't try to make sense of what's going on.

The general progression of this lifestyle is that family members lose self-esteem as the system gathers force and there is a general aura of underlying depression.

The family "rules" make it difficult for anyone to find out what is going on, unless the aberrant behavior is directly observed, such as the alcoholic doctor in the process of drinking, she said.

The therapist can often get a warning that something is amiss if family members seem to talk to each other as if they are strangers.

This lifestyle leaves the mother unsatisfied and unfulfilled, which is often expressed by a desire to "have a real family, instead of a bunch of people living together."

Adherence to the rules also results in a massive denial system.

Dr Knutsen says the alert therapist can often notice from the very beginning the message, "you can't catch me."

The therapist must avoid getting caught in this game, while following the general policy of trying to modify the "rules" the impaired physician's family often works under.

One advantage of family therapy is that it enables all members to get on with their own growth and development, said Dr Knutsen.

This is true especially with addictions where the family members tend to develop an identity in terms of the identified addict.

The task of the therapist is to get these members back on their own developmental tracks.

Despite its strong points, family therapy is often rejected by impaired physicians because they want to avoid the increased human contact that family therapy offers, said Dr Knutsen.



Smoking during pregnancy tied to more fatal disorders

ATLANTA — Smoking during pregnancy has now been linked to two disorders fatal to babies during the perinatal period.

The perinatal death rate due to Rh blood incompatibility between mother and child has been found to be 81% higher in women who smoke.

And the perinatal mortality rate due to birth defects is 43% higher in smokers.

These two new findings come from the United States government's Collaborative Perinatal Project and were reported by Richard Naeye, pathology chairman at Pennsylvania State University M.S. Hershey Medical Center, at the 67th annual meeting here of the International Academy of Pathology.

Last year, the same group revealed that women who smoke during pregnancy are much more likely to miscarry because of premature separation of the placenta from the wall of the uterus (abruptio placentae).

The Collaborative Perinatal Project, which was sponsored from 1959 to 1966 by the National Institute of Neurological, Communicative Diseases and Stroke, provides the most extensive data base now available to determine what effects smoking and other variables during pregnancy have on disorders of the fetus and newborn.

From information gathered on a total of 53,518 pregnancies, more than 1,000 medical, hereditary, demographic, social, and postmortem variables were analyzed.

Information on smoking habits during pregnancy was obtained in nearly 47,000 cases.

In addition to collecting data on gestation, labor, and delivery, the investigators conducted follow-up studies on the offspring to the age of eight years.

The investigators found that among non-smokers the incidence of death due to abruptio placetae during the first 21 weeks of gestation was only 1.55 per 1,000 births.

In contrast, the rate for women who smoked up to 20 cigarettes a day was 1.84 per 1,000; for those who smoked over 20 cigarettes a day, it was 7.63 per 1,000 or more than twice as common in heavy smokers.

Birth defects serious enough to cause death accounted for 3.57 per 1,000 births during the last four months of pregnancy in non-smokers and 5.12 per 1,000 in light smokers.

When there was an Rh blood incompatibility between mother and child, the mortality rate for the fetus or newborn was 1.36 per 1,000 in non-smokers, 2.01 per 1,000 for pack-a-day women, and 4.48 per 1,000 for heavy smokers.

An etiologic role for smoking in these three disorders seems plausible because of recently discovered effects of smoking on the placenta, said Dr Naeye.

The placentas of cigarette smokers have a number of struetural abnormalities characteristic of redueed maternal perfusion, including obliterative endarteritis and cytotrophoblastic hyperplasia in villi and necrosis of the decidua basalis at the margin of the placenta.

Nicotine temporarily reduces uterine blood flow and this provides a plausible explanation for the underperfusion.

The necrosis of the decidua basalis at the margin of the placenta found in smokers provides a nidus for premature placental separation and thus an explanation for the excessive fetal placental abruptions associated with cigarette smoking, he said.

New drugs added to Schedule H

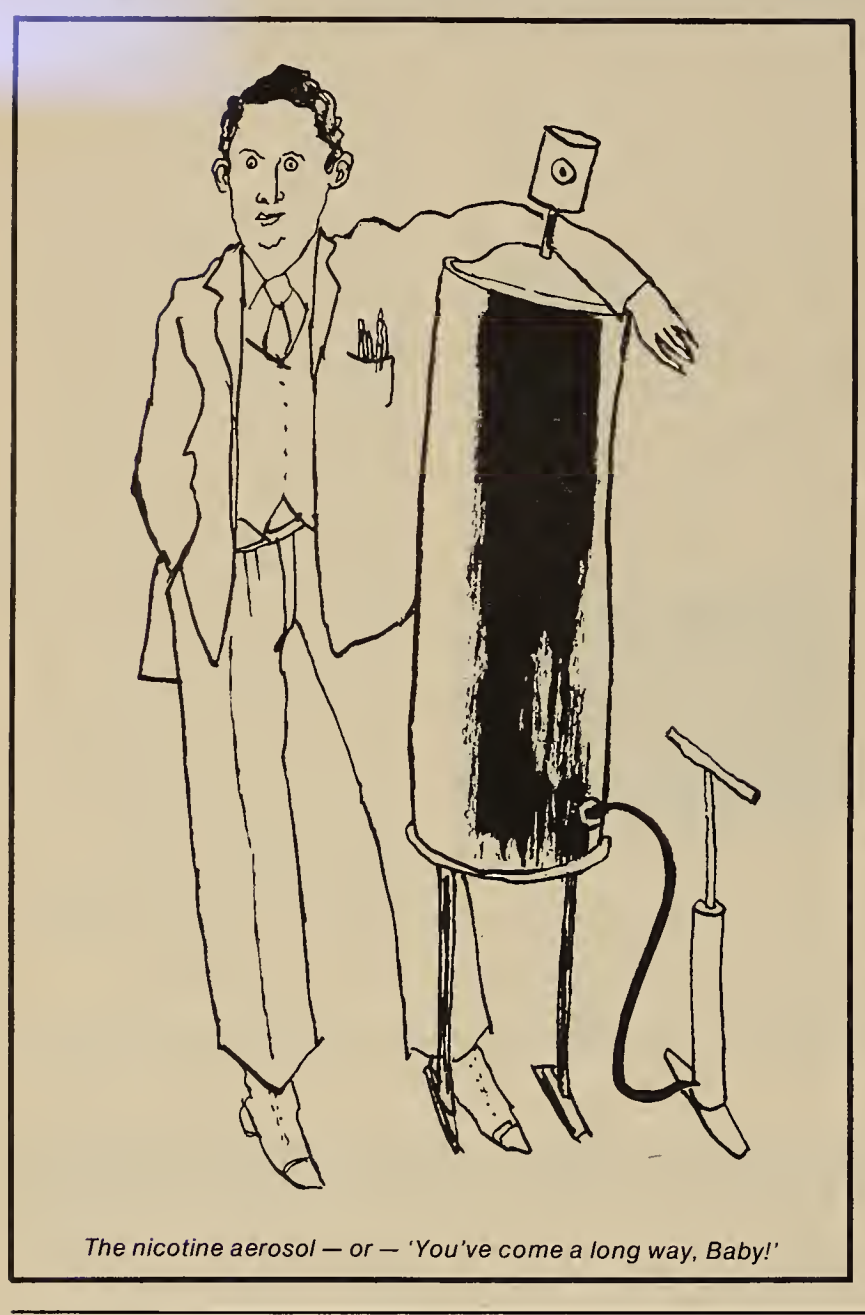
OTTAWA — The federal health department has added two more drugs to its Schedule H of hallucinogenic drugs covered by the Food and Drug Act.

One drug, 4-bromo-2, 5-dimethoxyamphetamine, is the latest man-made variant of amphetamines found on the street by police in major Canadian eities recently.

The health department routinely adds such new drugs to its various controlled drugs schedules, in an effort to keep up with underground laboratories constantly developing new variants not restricted by law.

The other drug added to Schedule H is N- (phenylcyclohexyl) ethylamine.

Nicotine zap from aerosol may replace smoking



The nicotine aerosol — or — 'You've come a long way, Baby!'

By Harvey McConnell

WASHINGTON — A squirt from an aerosol, replacing a puff on a cigarette, in a few years may be the way millions of smokers can kick the habit.

The first trial with an oral shot of nicotine has proved so successful that a much larger trial starts next month.

Gio Gori, of the National Cancer Institute, told The Journal: "Our first trial with the nicotine aerosol, involving 20 or so people who were heavy smokers, persuaded a number to stop smoking over a period of a couple of weeks.

"Others managed to reduce their smoking considerably."

Dr Gori, deputy director of the division of cancer cause and prevention at the NCI, said: "If people smoke because they need the nicotine in the cigarette, then if you give them the nicotine via the aerosol, presumably they don't crave smoking any more.

"If you have too much nicotine in your blood, then you don't smoke any more, because you have too much. A cigarette will just make you dizzy, or it will taste bad. After a while, you lose the incentive to smoke.

"This is the theory, and somehow it has been supported by our first, very preliminary, experiment. We hope it is going to be sustained by our new experiment."

Some 50 people will take part in the NCI-directed trial to be carried out by Dr Alfred Smith, of the American Health Foundation in New York.

The present aerosol is no neat, packaged vial. It is a cumbersome device with a handpump.

Dr Giro believes curing one problem may cause another: a smoker may give up cigarettes, but not the aerosol.

"However, if we take them off the smoke from the cigarette, that really is an achievement, because nicotine is only a minor part of the smoke," Dr Giro said.

"Smoke has a number of other toxic components, such as tar and carbon monoxide, that will not be present in the nicotine aerosol."

Research during the past two years has convinced Dr Giro there is not much danger in using the aerosol: "If a man sprays himself too much he'll lose consciousness and won't be able to spray any more."

And the problem of "aerosol addiction" will probably solve itself.

Dr Giro: "Even if in the future we have a little aerosol that one can spray into the mouth, it is still going to be an awkward thing.

"It is not going to be as acceptable socially to use it as it is now to light up a cigarette. People will have to do it surreptitiously — putting a hand over the mouth or covering up — and I think that will be sufficient deterrent to persuade the users of the aerosol to quit altogether.

"This nicotine aerosol is only a surrogate for those people who cannot quit smoking altogether. It has to be done over a period of time.

"Our first message is, obviously: stop smoking for God's sake."

There are millions however who want to, but can't, and the aerosol may be a substitute.

Dr Giro: "We seem to have a penchant for self-torture, and this may open up the possibility of a generation of people going around using the aerosol."

There are inherent dangers. Nicotine in small doses is a stimulant, a depressant in larger doses, and poisonous in very large doses.

Dr Giro said the NCI has had what he calls "modest success" in the past eight years in trying to devise methods and programs to help people stop smoking.

Clay mixed with tobacco was a failure. Smoking clinics have an average 20% "cure" rate.

Efforts by others to produce a nicotine chewing gum failed because the necessary concentration could not be reached.

"The fact remains we have about 50 million smokers in this country, so if programs have been successful, they have not been as successful as we would have liked."

One positive step Dr Giro believes the institute has made is research which has led to development of cigarettes they believe are less hazardous.

There are now some 20 brands of cigarettes on the American market with a low tar content and which are being heavily advertised.

Dr Giro says if a smoker decides to go to a lower tar cigarette he must make a gradual change: "If the changes are too sharp, the smoker is not going to accept a lower tar level. But today there are all sorts of tar level cigarettes and one can pick a level.

"My advice to a smoker would be to take a cigarette that is only 10% to 15% lower than the one he smokes today. Smoke it for a month or two until he gets used to it.

"Then pick another cigarette which is 10% to 15% lower again. Over a year or so one could get down to really low tar and nicotine levels."

Or the nicotine aerosol in a few years. But Dr Giro makes it clear that if the next trial is successful, there will be the question of safety, and approval by the Food and Drug Administration.

"We don't think of this as *the* answer to the problem of smoking. It is only one," he adds.

Food or liquor, not both

Gin and sandwich can cause fatigue

LONDON — A combination of alcoholic drink and carbohydrate-rich foods — the average English business person's lunch — may produce more afternoon fatigue than much larger quantities of alcohol alone.

This has been suggested by research conducted by Professor Vincent Marks and colleagues at the University of Surrey.

The researchers found that volunteers given gin and tonic (containing approximately 50 g alcohol and 60 g glucose) tended to develop lower blood glucose levels than when they were given a similar quantity of gin with a sugar-free tonic or a 60 g glucose tonic alone.

Some of those receiving the gin and tonic showed reductions in blood glucose concentration two-and-a-half to four hours later sufficient to produce moderate to severe discomfort due to neuroglycopenia.

Professor Marks writes in the bulletin (No 22) of the British Nutrition Foundation that the reason for this "particularly malign form of reactive hypoglycemia" appeared to reside in alcohol's ability, when present in a concentration of between 0.5 and 1.0 g per litre of blood, to potentiate the insulin-releasing properties of glucose or such rapidly glucose-yielding drinks and food as drink mixers (tonic), biscuits, sliced bread, and bread rolls.

"The quantity of alcohol and sugar given to the volunteers was equivalent to about three double gin and tonics and well within the amount consumed by some businessmen and others who are accustomed to eating or drinking a pub lunch rather than a more conventional one," he says.

"A few pints of beer is perhaps an even more common substitute for lunch than gin and tonic, especially when taken with a sandwich or bread roll. This mixture provides almost the same amount of alcohol and 'glucose' as was received by our volunteers.

"Whether, as seems likely, it also provokes as severe a reactive hypoglycemia, has still to be determined. It has, however, already been ascertained that when volunteers ate upwards of 100 g of solid carbohydrate-yielding food with their midday gin and tonic, it provided no protection from, and indeed occasionally exacerbated, the hypoglycemia effects of alcohol."

Professor Marks says that the symptoms of hypoglycemia — fatigue, lack of concentration, and lack of efficiency — do not develop until several hours after the completion of a bar lunch. Consequently, the gradual appearance during the late afternoon of a sense of undue fatigue, lack of concentration, and an increasing tendency to errors of judgment, might not be attributed to its true cause — hypoglycemia resulting from consumption of a sub-inebriating dose of alcohol plus carbohydrate yielding food.

"The overall importance of this nutritionally self-induced type of cerebral malfunction on work performance and safety has still to be assessed," he adds. "But it probably should not be underestimated due to the increasingly large number of people who indulge in a predominantly liquid lunch. Perhaps not all the adverse effects observed under these conditions are due to the direct effect of alcohol on the brain. Some of them may be due to hypoglycemia or a combination of both."

Sports heroes' alcohol ads alarm officials in UK

LONDON — The regularity with which British sporting professionals appear in advertisements for alcoholic drinks or tobacco is causing increasing concern.

In fact, Eric Deakins, undersecretary of state for the department of health here, has made it plain that ways to reduce the psychological impact of such advertisements are being closely examined.

He delivered his bombshell to the brewers and tobacco barons at a conference of European sports ministers during a debate on "ethical and human problems in sport."

Mr Deakins said: "One matter which has been causing us a great deal of concern is the extent and effects of advertising of tobacco and alcohol at sports events and the commercial sponsorship of sports activities by tobacco and alcohol interests.

"We are also very concerned about the presentation of sports stars and other heroes of the young in alcohol advertisements and the possible encouragement this gives to drinking among young people."

Mr Deakins' statement is in line with the now clearly discernible determination of leading British government politicians to stem the rising tide of alcohol abuse.

While the minister was speaking, two of his parliamentary colleagues, Helen Hayman and Sir George Young, were presiding at a House of Commons working party which has been set up to investigate and advise on alcohol-related problems.

The working party has been drawn together by FARE — The Federation of Alcoholic Residential Establishments — and is inviting both verbal and written contributions from interested parties.

FARE secretary Don W. Steele told The Journal:

"The federation represents a wide range of interests including psychiatrists and social workers as well as grass roots non-statutory organizations and projects whose hostels and counselling services comprise by far the largest part of current provision in this field.

"We will be looking at the casualties which appear to be rising from the steady increase in the amount of alcohol consumed (beer up from 182.4 pints per adult per year in 1955 to 268.7 pints in 1975; spirits 2.3 pints per person per year up to 5.9 pints; and wine, a five fold increase during the same period).

"The percentage of the prison population whose offences are directly and indirectly related to drink will also come in for examination, as will the progress which has been made since the Home Office Report on Habitual Drunken Offenders appeared in 1971."

Mr Steele said that in 1971 it was estimated that alternative facilities for 2,000 men and 200 women would have to be provided if the practice of sending people to prison for drink offences was to cease.

Some action had been taken in response to the report, but questions needed to be asked about its extent and effectiveness.

Cigarette smugglers tracked in PA

HARRISBURG, PA — Advertisements are being placed in Southern newspapers by the state of Pennsylvania offering a reward for tipoffs on people trying to smuggle cigarettes into the state.

The offer is 50 cents for every carton confiscated. As most of the cigarettes are brought in by the tractor-trailer load, a tipster could earn up to $30,000 if a full load is captured.

Pennsylvania estimates it loses some $400 million a year in unpaid cigarette tax. The cigarettes are smuggled in and sold at cut-rate prices.

Pennsylvania, like many northeast states, has a high cigarette tax. The lowest in the nation are in North Carolina and Virginia, two tobacco growing states. The Virginia legislature turned down recently a move to raise the pack tax to try and deter smuggling.

In the United Kingdom

Multiple drug misuse major problem of 1970s

By Alan Massam

LONDON — The British secretary of state for social services, David Ennals, has now accepted what field workers have been telling him for two years — that the pattern of drug misuse here has changed significantly.



David Ennals

He publicly acknowledged at a rehabilitation centre meeting in Southampton that a "timely reappraisal of the services being provided for drug misusers has begun."

Mr Ennals said the present services were established in 1968 when the government was concerned about the growing number of young people misusing heroin and other narcotic drugs.

"It was feared then that there would be an explosion of narcotic addicts; but this has not occurred," he said. "At the end of 1976, only 1,881 people were known to be receiving treatment for addiction to narcotic drugs, lower than the peak figure two years earlier.

"I accept that this is only a guide to the number of drug misusers in the United Kingdom — it is not possible to quantify those illicitly misusing narcotic or other drugs," the minister went on.

"But, the evidence suggests that their number is not likely to be higher than that of the notified addicts. In comparison with several other countries, the problem of narcotic drug abuse appears to have been contained.

"However drug misuse is still a cause for concern. The recent report of the Treatment and Rehabilitation Working Group of the Advisory Council on the Misuse of Drugs says the problem has not diminished, but changed.

"Multiple drug misuse involving a wide range of psychotropic drugs, including barbiturates, is probably the major problem of the 70s."

Mr Ennals said this type of misuse was not confined to narcotic addicts. The Advisory Council's report, he stressed, had pointed out that the London drug treatment clinics (set up in 1968 to "contain" the narcotic threat) were more heavily loaded than ever.

One of the major voluntary agencies in the field, the Helping Hand Organization, recently claimed government clinics were dealing with one client population while the voluntary agencies were dealing with another.

"We had expected a major source of referral to come from the drug dependency clinics, but in the eventuality this did not materialize," the organization said in a report.

"The reasons for this are not entirely clear, but may be related to the schism that has long been in existence between the statutory and voluntary responses to drug addiction."

The organization further reports that the main thrust of its work over the past 18 months has been around Piecadilly Circus (the central London nightlife quarter south of Soho, known for many years as a congregation point for drug addicts).

It says it has established a contact point in one of the exits from Piccadilly Circus Underground (subway) station, where most drug misusers were found to have had little or no contact with statutory (government) social agencies and tended to regard them with some suspicion.

"For many, their experience of social workers has been that of people who exercise a power function over them, by putting them in children's homes in early life or in mental hospital," the report adds.

"Our presence in subway 4 has been used by the habituees in a variety of ways. For some, it provides a chance to talk about subjects other than drugs, for others we have provided advice on accommodation, law, or employment agencies.

"It is interesting to note that the majority of people we contact at Piccadilly are not receiving treatment from a clinic. Many have, at some time, been registered (on the official Home Office register of addicts, a necessary requirement before heroin can be preseribed at a government clinic, the only legal source) and many more are young people who may not have tried to get treatment.

"This is largely because they do not usually have a heroin or methadone addiction. Indeed the current market price of these drugs is such that only those with plenty of money can afford them. In consequence, most people we meet will take any drug they can procure. Although some drug dependency units provide a few hours a week for dealing with these drug users, the majority regard themselves as specialists in treating opiate addicts.

"Furthermore, the difficulty there is in dealing with people on barbiturates does not endear them to clinics. There is little incentive for 'polydrug' abusers to attend clinics for there is little likelihood of receiving a prescription.

"One measure of the success of our detached work is the way in which long term drug users will occasionally bring across a young person who is endeavoring to purchase drugs and ask us to try and sort him out."

** Drugs, Suburbia, and Subway — The Pattern of Addiction of the Seventies — Helping Hand Organization, 8, Strutton Ground, London SW1 P2HP.*

Pentazocine abuse leads to FDA scheduling

WASHINGTON — The analgesic pentazocine (Talwin), which has been on the market a number of years, has now been made a scheduled drug by the controlled substanee advisory committee of the Food and Drug Administration.

The drug has been placed in schedule IV, which is for drugs with a low potential for abuse. It has been unrestricted until now.

Evidence given to the committee showed there have been 133 overdose deaths from pentazocine.

It is also being abused by three groups of people: those with chronic pain; doctors, nurses, and pharmacists; and street addicts who turn to it when heroin is in low supply.

The scheduling will allow the Drug Enforcement Administration to keep a closer eye on supplies and aid in investigation of any diversions.

Evidence was given that one million units of the drug were diverted from a pharmacy, for example, and tracing had been very difficult.

Committee member David Smith, of San Francisco, who voted for the scheduling, told **The Journal**: "Although a lot of people have realized this drug is being abused, for many doctors this will be the first time they have been alerted to the fact pentazocine has any abuse potential at all.

"Another thing is that there are a number of questions that need to be answered about this drug, and scheduling will allow a closer study," said Dr Smith of Haight-Ashbury Free Medical Clinic.

Researchers receive award for methadone work

SEATTLE — The two developers of methadone maintenance in the United States were selected by the National Drug Abuse Conference as the first recipients of its annual award for outstanding contribution to the field of drug abuse prevention.

Vincent P. Dole and Marie Nyswander of Rockefeller University, New York, began their methadone studies in 1964 with the New York Health Research Council. The success of the research led to major expansion of the study in 1965, and to federal subsidy and encouragement of sueh programs in 1971. Today, some 700 methadone maintenance eentres exist in the US.

Dr Dole is the president of the Board of Trustees of the Community Treatment Foundation, which reviews and evaluates the progress of patients in methadone centres throughout lower New York state. In addition, he is performing laboratory experiments on mice concerning the impact of parental addiction on offspring.



Vincent Dole

Dr Nyswander is a psychiatrist, and runs the Beth Israel Methadone Clinic in New York. She is the author of *The Drug Addict As Patient*.

Dr Norman Zinberg, head of the eommittee which made the selection, said: "Methadone maintenance has shown itself to be five to six times more effective in preventing heroin abuse than detoxifieation or therapeutie communities alone. Drs Dole's and Nyswander's pioneering efforts and scientific excellenee were crueial contributions to helping the addict."

Smokers' rights not law's job

WASHINGTON — United States government employees who want to have smoke free offices should not look to the law for a solution, US District Court Judge Charles Richey has ruled.

He dismissed most sections of a suit brought by workers seeking to require the government to restrict smoking to certain areas of federal office buildings.

Judge Richey said he did not wish to denigrate the importance of the environmental claims brought by the plaintiffs, "but such matters are better left to the legislative or administrative process."

These present a better forum for a proper balaneing of interests "where such social decisions can more appropriately be made."

The plaintiffs claimed the government was required to provide them with healthy indoor air in their workplace.

Whither DuPont?

SEATTLE — There is angry response from leaders in the field to what they claim is "the proposed firing" of Robert DuPont as director of the National Institute on Drug Abusc in the United States.

Delegates at the National Drug Abuse Conference here, passed a resolution supporting Dr DuPont's "continued directorship."

Dr DuPont was unavailable for comment to explain the "proposed firing".

Lloyd Johnston, social psychologist, University of Michigan, asked NDAC deiegates to support Dr DuPont in light of "unappropriate motives" for what he called Dr DuPont's impending dismissal: "I haven't heard any question of Dr DuPont's performance, that leaves only personal or political motives for such an action... This sets a very dangerous precedent which has a two-edged sword in future administrations."

David Smith, medical director of thc Haight-Ashbury Free Medical Clinic, seconder of the motion said: "I think this motion not only protests his firing, but also protests the proccss by which he's going to bc fired. Secretary Califano's process is as bad as his decision." (Joseph Califano is secretary of the US department of heaith, education, and welfarc).

Barbiturate deaths decline

WASHINGTON — There has been a drop in barbiturate overdose cases over the past 12 months in the United States and in the prescribing of the drug by doctors.

An official at the Office of Drug Abuse Policy (ODAP) told **The Journai**: "There has been a steady decline in deaths and injuries from barbiturates, and we attribute it to a voluntary restraint on the part of physicians."

Figures issued by the Drug Abuse Warning Network (DAWN) showed total emergency room visits for barbiturate overdoses declined from 2,923 in the first quarter of 1977 to 2,612 in the third quarter.

Overdose deaths from barbiturates last year fell from 201 in the first quarter to 177 in the seeond quarter. Third quarter figures for overdose deaths are not yet available.

The ODAP officials say it appears doctors are writing fewer prescriptions for barbiturates following President Jimmy Carter's message last year and publicity from the drug policy office.

"We are not recommending barbiturates be removed from the market but we have been advocating a greater degree of restraint in their use," the ODAP official added.

"Physieians are responsible people and the publicity has been enough to make them think about the number of tablets they may prescribe or look for safer alternative drugs to use."

Firemen go smokeless

ALEXANDRIA, VA — Fire Chief Charles Rule has decided that in future new firemen will have to pledge they will not smoke, on or off duty in this suburb of Washington.

Mr Ruie, who smoked a pipe for 22 years until he stopped last July, said his ruling has been made on practical grounds.

Under Virginia law, firemen who suffer pulmonary diseases or heart attacks are presumed to be incapacitated as a result of their joh. They can retire with an extra large pension.

Mr Rule said he did not think the city should suhsidize smokers under these circumstances.

EDITOR
Anne MacLennan

STAFF WRITER/PRODUCTION EDITOR
Karin Pargas

CONTRIBUTING EDITORS
Harvey McConnell (Washington)
John Shaughnessy (Toronto)

SCIENCE EDITOR
Dr Ruth Segal

The Journal

Published by Addiction Research Foundation of Ontario
33 Russell St, Toronto, (416) 595-6053

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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Inside Science

Community action on solvents, aerosols

By Keith White

Project Solvabuse, operating in Hamilton, Ontario, is mobilizing community resources around the problem of solvent and aerosol abuse.

The project is equipping these extant resources with the knowledge and skills necessary to treat solvent abuse and associated problems on a continuing basis.

Project Solvabuse is an independently sponsored Canada Works Project operating under the auspices of the Addiction Research Foundation (Hamilton). To meet its objectives, the project was awarded a grant of $31,000 to employ a staff of five for a period of 10 months — from November, 1977, to August, 1978. The staff consists of one full-time researcher, two field workers, a clerical worker, and a project manager.

Of the 10 months allocated for the project, the first four months comprised an initial research phase, necessary in order to determine both the prevalence of solvent abuse in Hamilton and the extent of existing community resources and their capability to deal with cases of abuse.

Whether Hamilton has a higher incidence of solvent abuse than other urban centres is problematic. There are a number of factors which make the collection of accurate data in this matter extremely difficult. These are the absence of regulatory controls and thereby some means of monitoring and/or controlling sales; and the fact solvents are most frequently abused in isolated areas (parks, empty houses, schoolyards, etc).

'Workers in the field were unfamiliar with the physiological and psychological effects of solvents and aerosols . . .'

In addition to the above problems is the fact that accurate reports of solvent abuse cases are not kept as a matter of course. Thus, in the 37 health and social service agencies surveyed, (complete survey results may be obtained by writing the Hamilton Centre ARF, 103 John Street South, Hamilton, Ontario, Canada) it was estimated that approximately 300 cases of solvent abuse or related problems were encountered.

Our chief concern, however, was not primarily related to the number of abusers. After some preliminary investigation of the extent of the problem in Hamilton, there was some concern on the part of the ARF's centre director here that a rather disturbing pattern was developing in referrals of solvent abuse cases.

This problem was manifest in the fact that workers in the field agencies were unfamiliar with the physiological and psychological effects of solvents and aerosols, as well as other basic information as to what precisely these substances were, their active ingredients, and so on.

Thus, a need for a means of ensuring inter-agency and inter-professional cooperation was demonstrated. In order to meet this need, an informal 'network' of agency professionals was established.

It was felt that these workers and professionals would benefit from such information, not only in the short term, but in the long term as well. By providing this service we would aid in ensuring that those seeking help with a solvent problem or parents seeking information receive adequate, informed advice. It was also hoped that by providing at least basic treatment information, we would thereby aid in ensuring that unnecessary referrals to, for example, medical and psychiatric assessments, would not be made.

To facilitate development of this 'network' we are providing a series of workshops and related programs dealing with assessment, treatment, and preventive measures in cases of solvent abuse. Those invited to take part in the workshops include social workers, youth workers, alcohol and drug counsellors, social service agencies and others. In addition, we are presenting a Grand Rounds for concerned medical personnel on aspects of solvent abuse treatment. The Rounds will be presented by Drs Fred Glaser and Adrian Wilkinson of the ARF.

Concurrent with the above activities, the project is involved in: documenting consumer complaints regarding excessive, irresponsible retail sales of solvents to abusers, and associated acts of vandalism; relaying such information to the manufacturer(s) concerned; disseminating materials on solvent abuse to parents and other concerned citizens; and compiling a handbook on the problem which will delineate available resources and be made available to the community at large. We will also make recommendations on aspects of the problem to local and provincial government officials and to concerned social and health agencies.

Such measures will provide a prototype and, to some extent, an evaluative model of the community-wide program detailed in the ARF's Information Review *Concerning Solvents and Aerosol Abuse*, which constituted the methodological basis for the project. As well as meeting a need in the Hamilton community, it is hoped the activities engaged in, and the materials produced, will serve as a model for anyone wishing to undertake a similar program in other areas where such action may be indicated.

In comparison with other drug and substance abuse problems, the incidence of solvent abuse is admittedly rather low. However, the propensity for serious physiological and psychological impairment inherent in these substances, especially aerosols, makes the need to provide practical solutions essential. The virtual universal availability and relative low cost of solvents and aerosols, the obvious impracticability of controlling sales to abusers, and the lack of efficacy in legislative measures as a means of control, all serve to augment the need for such solutions.

Thus far, community response to our program has been enthusiastic, making the prospect of the development of a community resource network most promising.

(Mr White is project manager of Project Solvabuse.)



Backgrounder

Drugs forcin

By Tony Garnier

WELLINGTON — The New Zealand government is considering the introduction of the death penalty for hard drug trafficking.

The introduction of flogging, longer prison sentences, telephone tapping, and electronic surveillance are also under active consideration.

Supported by many government and opposition members of parliament, the call for tougher penalties for drug trafficking and abuse follows widespread public concern about what is clearly a mushrooming problem.

But, that such drastic solutions are being advocated has been widely interpreted as confirmation of research evidence suggesting a fundamental swing to the right is taking place in New Zealand politics under the leadership of "populist" Prime Minister Rob Muldoon.

The ordinary New Zealand citizen is no longer concerned about party labels, it appears. Instead, he/she is more concerned with the attitude of the politicians to such concepts as authority, change, values, and so on.

The evidence suggests the New Zealand voter has become "reactionary", searching for a father figure in a world of uncomfortable change.

New Zealand's expanding hard drug problem has rapidly become the leading scapegoat contender as "the emotive issue" for this year's general election campaign due later this year.

The increasing number of court cases and customs hauls involving drugs, especially heroin, suggest to many people that a hard drug "cult" has in the past five years quietly worked its way deep into the fabric of New Zealand society. Many people are supporting calls to root it out.

In 1973, there were six offences before the courts involving heroin. Last year there were about 250. Until 1972, customs rummage squads had never found heroin. In 1973, they made their first few hauls. The finds then increased both in number and in quantity of drug found.

New Zealand's hard drug problem may be small by international standards. But for a tiny, insulated country with barely three million, mainly middle-class people, it represents a major threat.

In the past five years, scores of mostly young New Zealanders have succumbed to heroin-related deaths.

A call from senior police and others for increased powers to deal with drug trafficking has received wide support. In particular, police want powers for telephone tapping and electronic surveillance. It has been mainly the public, though, who want the death penalty and flogging introduced as punishments for hard drug trafficking. The argument has been "drug trafficking is worse than murder."

The death penalty was abolished in New Zealand in 1968 for all but the offence of treason.

A government committee under the chairmanship of speaker designate Dick Harrison spent the first three months of this year assessing the extent of the problem. Enough evidence has been found, says Mr Harrison, "to convince us there is a Mafia-type drug organization here in New Zealand."

The committee had been convinced that murder and the severe beating of victims was now part of the New Zealand illicit drug scene. Legitimate business operations were being used as a cover, he believed. He had known for a long time that New Zealand had a "huge" alcoholic

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Editor... Letters to the Editor... Letters to the Editor...

Cannabis factsheet concerns me: Ungerleider

This communication was occasioned because the "factsheet" on cannabis (**The Journal**, January) made me vaguely uneasy.

A number of alleged effects or possible implications of taking marijuana are mentioned as though they were factual and, although disclaimers are there, the entire presentation seems designed to make one extremely concerned about cannabis.

Phrases like: "midjudge the passage of time ... similar to those of LSD and other hallucinogenic drugs ... soluble in fats ... level builds up and is gradually released into the body system ... one out of 20 users becomes psychologically dependent ... possibility of physical dependence ... an added risk of lung cancer ... loss of energy ... confused thinking, impaired memory, and lack of interest in any planned activity ... amotivational syndrome ... diarrhea, cramps, weight loss ... blockage of blood vessels and loss of sex drive ... chromosome damage, reduce levels of male sex hormone in the body, reduce body defences against infections, brain and liver damage."

'Where is the factsheet's mention of the exciting possible therapeutic uses of cannabis ...?'

Despite the disclaimers, these frightening phrases stand out, and are not contrasted in any way with the kinds of other activities in human life that also could be described in similar fashion: for example, psychological dependence on television, chromosome damage from caffeine and aspirin (the latter drug is causing several hundred overdose deaths a year) plus the real lack of proof for these dangers from cannabis that are listed.

The factsheet reads like the informed consent forms that we use in our marijuana/cancer chemotherapy research project where almost every adverse reaction to marijuana that has ever been reported has to be described to the patient. In addition, where is the factsheet's mention of the exciting possible therapeutic uses of cannabis in cancer, glaucoma, asthma, pain, alcoholism, and epilepsy which are being researched?

J. Thomas Ungerleider, MD
Associate Professor of Psychiatry
UCLA Medical Center
Los Angeles, California

Reprinted from The Journal, April 1978

Toxicity evidence 'soft': Smith

I am concerned about the cannabis factsheet (The Journal, Jan).

I believe this factsheet cites a great deal of soft and suggestive evidence relative to the toxicity of cannabis without adequate explanation that these observations are far from proven.

Further, I believe the whole area of therapeutic use of cannabis, where documentation is occurring at a substantially higher rate, has been left out. For example, at the present time, there is substantially more evidence that cannabis reduces intraocular pressure, and may be valuable in the treatment of glaucoma, than there is that cannabis causes chromosome damage.

In fact, the evidence relative to the therapeutic use of cannabis is escalating at such a rapid rate, that in the relatively near future in the United States cannabis may be rescheduled from Schedule 1 to Schedule 2, indicating its medical uses.

I request that The Journal give a more balanced view of cannabis in future issues, with more documentation of the degree of proof for some of its toxicological statements, and more emphasis on the growing body of information that support the potential therapeutic uses of cannabis.

David E. Smith, MD
President, Youth Projects
Medical Director,
Haight-Ashbury Free Medical Clinic

Double standard obscures facts: Kalants

Drs David E. Smith (**The Journal**, April) and J. Thomas Ungerleider (**The Journal**, May) have written to complain about the cannabis Factsheet published in the January issue. The basic criticisms are that the effects of cannabis described as facts are far from proven, and that the presentation is unbalanced because it omits description of the potential therapeutic uses of cannabis.

Though the Educational Resources Division of the ARF and the editorial staff of **The Journal** are responsible for the format of the factsheets and the decision to publish them, accountability for the substantive content lies primarily with the expert consultants, who vary from topic to topic. We are writing this reply because we were the primary consultants for the cannabis factsheet.

The description of the effects of cannabis is based on a careful and critical evaluation of the international literature carried out during the past 13 years. It is based on clinical, experimental, and epidemiological studies, and the conclusions have been drawn exclusively on the basis of the intrinsic merits of each case, rather than of any preconceived views. We have let the chips fall where they may. We have not relied on the judgments or opinions of other workers in the field, but on our own assessment of the primary evidence they have provided.

The criteria used in this process of evaluation have been the same as those used to assess the effects of amphetamine and cocaine (**The Journal**, February, 1978). Dr Smith refers to "soft and suggestive evidence" and Dr Ungerleider to "lack of proof." We disagree with their opinions, which are not backed by any clear definition of what they consider to be valid "proof." Consensus about the adverse effects of a drug is generally reached through a very complex process of assessing and weighing evidence of many different kinds, ranging in texture from the very soft to the very hard. This applies to all psychoactive drugs, from the most to the least controversial. In our judgment, the criteria generally used for the evaluation of evidence on the effects of cannabis have been the least consistent and the most subject to the influence of the evaluator's bias. People who have adopted a very conservative attitude towards cannabis have uncritically accepted as proven any claim concerning the adverse effects of the drug on health, while those who have adopted a very liberal attitude have tended to dismiss most claims on the grounds that the evidence is unreliable or "unproven".

But, curiously, a great many of the latter group apply a double standard, accepting as valid in relation to other drugs the same type of evidence that they reject when applied to cannabis. If the effects described in the cannabis factsheet are considered unproven by Drs Smith and Ungerleider, then many of the effects currently accepted as proven for all other psychoactive drugs should be considered equally invalid. We wonder why no one demands the same rigid scientific standards of "proof" for alleged effects of other drugs, including alcohol, the current *bete noire* of the drug scene. We would point out that no one has "proven" that alcohol causes cirrhosis in humans, though no sensible investigator seriously questions it. If Drs Smith and Ungerleider wish to debate point by point, with full documentation, the scientific evidence supporting our statements, we would be happy to do so.

Dr Ungerleider has taken a series of phrases out of context, and labels them as "frightening." While this may be his reaction to them, it does not make the statement untrue. The factsheet clearly differentiates between effects of light and heavy use, and between effects which we consider well documented and those alleged but not, in our view, adequately substantiated. Unfortunately, Dr Ungerleider dismisses this differentiation as "disclaimers."

Both Drs Smith and Ungerleider suggest that a more balanced picture of cannabis would be attained if some prominence had been given to the potential therapeutic applications of cannabis. This again is an instance of a double standard because there has been no particular emphasis put on the therapeutic uses of any of the other drugs included in the factsheet series. The factsheets deal primarily with the effects of non-medical use of drugs. Medical applications have been briefly mentioned only in the case of drugs which currently have an accepted therapeutic use. This is not the case with cannabis at the present time. The potential medical applications of this drug and its derivatives are very interesting, but to be consistent we should include them in the factsheet only when they become accepted in medical practice. Moreover, the fact that a drug may have a recognized therapeutic use is really quite irrelevant to the question of whether or not its non-medical use may have adverse effects. The opiate analgesics are a prime example of this.

Finally, Dr Smith requests that: "**The Journal** give a more balanced view of cannabis in future issues ...." We should like to emphasize that **The Journal**, since its inception, has dealt with the cannabis issue in great depth. Most major developments in the area, and every conceivable point of view, have found expression in its pages, sometimes to the exasperation of some members of Addiction Research Foundation staff, including ourselves. In all fairness, **The Journal** cannot be accused of having given an unbalanced view of this topic.

Oriana Josseau Kalant, PhD
Harold Kalant, MD, PhD
Research Division
Addiction Research Foundation
Toronto

NZ into 'reactionary' corner

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erhaps a majority of New
arijuana is not regarded as
" drug. Parents certainly
heir sons or daughters get caught using the drug. But they don't regard its use as a health risk. The "stupid thing" about marijuana use is to get caught breaking the law.

In contrast, most New Zealanders are aware of the dangers of heroin. It is not simply stupid to get caught: it *is* dangerous to health to use it.

Still, some authorities have suggested to the Harrison committee that before it embarks willynilly on recommendations of wider police powers and steeper penalties, some basic issues require examination. In particular, researchers have noted that about half of New Zealand's violent offending involves abuse of the far more commonly used and available drug, alcohol. At least 80% of each year's thousands of injuries and more than 700 fatal road accidents, are said to be alcohol-related.

In short, the controls on all socially used drugs — heroin, alcohol, marijuana — need to be questioned in a context of the need for New Zealanders to take some remedial action to bring about the kind of society they really want in the future. A prior need to bring about a better New Zealand involves getting into clearer focus the relative "risks" against "benefits" associated with use and controls of all socially used drugs, including alcohol.

A debate, of sorts, is now warming up and likely to get hotter as the election approaches. But so far, the talk is largely around fixed points of view.

On the one hand, many politicians appear to assume the public will endure anything — hanging, flogging, telephone tapping, and electronic bugging — in order to see the trafficking of heroin and marijuana stamped out.

In contrast, on alcohol, many of the same politicians believe the community will not endure tougher penalties and the random breath testing of motorists. Yet clearly alcohol is a far more life-endangering drug than heroin (because of the amount used). And it seems almost beyond question that alcohol is more dangerous than marijuana, both in terms of personal health risks through use, and the resultant potential effect of producing harmful behavior to others, either through violence or bad driving.

But, just in case, it has been suggested to the Harrison committee that it should advocate long term research into the comparative qualities of both alcohol and marijuana. It has also been suggested that New Zealand might curb its heroin problem by following Britain's example of regarding heroin addiction as a medical problem, not a crime.

Meanwhile, despite the political risks involved, some politicians are pushing for tougher penalties on the alcohol front. In an uncharacteristically tough speech on the issue, former Labour Prime Minister Bill Rowling recently argued that the only way to make New Zealanders reconsider their traditional drinking and driving behavior was to make them "too damn scared to do it."

Perhaps the most enlightened measure in the government's package is a plan to establish a working party to examine the feasibility of introducing rehabilitation programs for re-offending alcohol-impaired drivers. Early reaction is that such programs will prove impracticable and ineffective.

Certainly, the public clamor for urgent action to curb heroin and marijuana trafficking is not visible with alcohol abuse. It is evident that New Zealand's massive drug problem will be around a long while yet, until the will to beat all drug abuse surfaces.

1st class

May I congratulate you and your staff for producing a first-class newspaper. I find all the articles interesting, and thank you for your ample coverage of the scene in Britain.

Iain McQueen
Media and Communications Officer
Scottish Health Education Unit
Edinburgh, Scotland

The Journal welcomes Letters to the Editor. Letters, bearing the full name and address of sender, should be sent to: The Journal, 33 Russell Street, Toronto, Ontario, Canada, M5S 2S1.

New neuro-therapy for drug addiction under UK scrutiny



By Alan Massam

LONDON — A novel treatment for addiction based on traditional Chinese acupuncture is to be scientifically evaluated in Britain.

The technique, developed by Meg and George Patterson, involves passing an electric current through electrodes attached to a patient's ears. This "neuro electric therapy" is said to eliminate withdrawal symptoms such as cramp, nausea, and running nose and to remove craving for hard and soft drugs and alcohol.

Dr Patterson was practising as a surgeon in Hong Kong when she first became aware that patients given anesthesia with an electro acupuncture machine were freed from withdrawal symptoms if they happened, coincidentally, to be drug addicts.

Hong Kong is possibly the only place where such an observation might occur since one in 16 of the population is addicted to either opium or heroin to some extent.

Dr Patterson quickly recognized the significance of the observation and returned to London in 1973 to develop the technique and continue her research.

Since then, widespread interest has been expressed in the claims, notably by Dr Peter Bourne, formerly campaign adviser to United States President Jimmy Carter and now his adviser on drug abuse. However, official agencies in the US and Britain were not prepared to finance a trial.

The British Broadcasting Corporation made a TV film Still Off The Hook about some of the Pattersons' treatment successes and it provoked widespread protests here because the couple were then thought to be taking their skills to a clinic in the US.

Dr Meg Patterson told **The Journal** that financial backing to allow her and George to evaluate the technique had finally come from a British charitable trust, the J. Arthur Rank Foundation.

She said: "I call the technique neuro electric therapy or NET.

"Essentially, we pass a low electric impulse through the patient's brain. In Hong Kong, we used to give three electrical treatments of 40 minutes duration over a period of 24 hours, usually when the patient was in acute withdrawal.

"The benefits in terms of relief from withdrawal symptoms could been seen in as little as 10 minutes and within half an hour there had been a great improvement.

"Now we don't give the treatment during the withdrawal stage and have developed a supportive therapy to run alongside the electrical treatments."

Dr Patterson emphasized that a patient released from the craving for a drug remained aware that he could escape from emotional pain by using it again. After the treatment, however, patients were free to make their own decisions about whether or not they really depended on the drug.

She said she had been frustrated by the delays and indecision which had prevented the setting up of a clinic earlier and there was still some pressure on her to visit centres in the United States.

With the support of George — a "natural therapist" and former medical missionary in Tibet — and the J. Arthur Rank Foundation, she intends to set up the new clinic in the north of the County of Kent, south-east England, for fee-paying and "charity" patients referred by doctors and other agencies.

"There is no shortage of patients, I can assure you," she said. "The official figure given for the number of addicts in this country is very much the tip of the iceberg. There are far, far more and many of them get very little treatment or support."

Among Pattersons' patients while they were in London was rock guitarist Eric Clapton, now back on the stage after four years of addiction.

(Address: Roughets, Cowden, Near Edenbridge, Kent (phone Cowden 231)

Hungary tries water ploy to dampen alcoholism

MUNICH — Hungary has enacted strict new measures to control alcohol consumption.

Effective last January, the sale of alcoholic beverages before 9 am on working days has been banned in all outlets except hotels and restaurants catering to international tourists.

In addition, no alcohol can be sold in restaurants, or refreshment stands at railway and bus terminals or at river embarkation points.

The decree, issued just before Christmas by the ministry of domestic trade, also limits the number of stores permitted to sell alcoholic beverages. Vegetable, fruit, and meat shops have been banned entirely from selling alcohol, and the range of beverages in other types of stores has been sharply curtailed. Those specializing in coffee, tea, sweets, and high-quality foods are now limited to stocking only luxury drinks such as liqueurs, brandy, champagne, and dessert wines. Self-service restaurants may sell only beer.

No bars, wineshops, or stores selling spirits are to be located within a 200-metre radius of any factory or office employing 100 or more people.

The edict also requires restaurants to expand their range of non-alcoholic beverages, and those with a lower alcohol content.

Water is to be placed on every table. Mineral water must be available in smaller quantities than the usual one-litre bottles, and wine must be sold in carafes or by the glass in addition to full bottles. Until now it has been impossible to obtain anything less than a 0.7 litre bottle of wine in any Hungarian restaurant.

The new measures follow a series of edicts issued in the summer of 1976 which prohibited advertising or publicity advocating alcohol consumption and placed a total ban on the sale of alcoholic beverages of any kind in the cafeterias, canteens, snackbars, and refreshment rooms of factories, business, and government offices.

Hungarian sources place the country at the top of the world league in consumption of distilled spirits in third place for wine, and fifth for beer.

Alcohol abuse has become a mounting problem, and according to one recent survey, consumption is on the increase among the young.

For smokers

How to cut classes

MUNICH — Evening classes on how to stop smoking will soon be offered in about 200 West German adult education centres.

The 10-week, 90-minutes-per-week therapy program, which will cost participants a mere 25 marks (about US $12.50 at the present exchange rate) was developed by the Max Planck Institute for Psychiatry in Munich.

Some 21 instructors are currently undergoing training at the Cologne-based Center for Health Information, an institute of the federal ministry of health, and scores of others are expected to attend the training program within the next weeks and months. They will then be equipped to apply the methods at *Volkshochschulen* — adult education centres — all over the country.

The essence of the program is that smokers are not required to stop instantly. Instead, they are taught to analyze the situations and behavioral influences that induce them to smoke, then how to exercise control over the habit with the aim of eventually giving it up altogether.

New Zealand's drivers face more controls

By Pat McCarthy

AUCKLAND, NZ — Tighter controls on both drunken driving and the cigarette industry are planned in New Zealand this year.

Drunken drivers are likely to face a simplified system of breath testing — and a reduction of legal loopholes.

Under present procedure, a suspect must receive two screening breath tests, followed by a blood test, and there are at least 64 legal points on which a defence lawyer can challenge a prosecution for a blood-alcohol concentration exceeding the limit of 0.1%.

The proposed system would institute an offence based on a breath-alcohol proportion exceeding 500 micrograms of alcohol per litre of expired air.

A screening test would be followed by a breath test on an electronic device that would classify the driver as "definite positive," "doubtful positive," or "negative." No further test would be required for the first category, except if a suspect insisted on a blood test (at his own expense unless it proved negative).

Random breath tests are also being discussed by the government. The Prime Minister, Robert Muldoon, has said they might be introduced for drivers leaving hotels. Taverns with large car parks are a feature of New Zealand suburbia.

Official figures say the involvement of alcohol in fatal road accidents has increased from 19% in 1972 to 37% in 1976, but pathologists have claimed that 60% of traffic deaths involve excessive alcohol consumption.

During a 10-day strike by Auckland brewery workers in 1976, no motor accident victims were admitted to the head injury unit at Auckland Hospital — a record respite.

For the cigarette industry, three restrictions are reported to be planned by the government's committee on smoking and health.

These are tougher health warnings on cigarette packets, compulsory publication of tar contents (in line with United States requirements), and a cut in advertising and sports promotion.

The last of these is likely to meet most resistance — both from the industry and from sports bodies. Rugby, horse racing, soccer, tennis, yachting, bowls, motor racing, rugby league, hockey, and motor cycling all receive cigarette sponsorship.

Around the World

Schizophrenia

Preliminary results from a British survey of schizophrenics indicate these patients may be more than usually susceptible to the effects of alcohol, and that many of them are heavy smokers. A spokesperson for the survey, by the Schizophrenia Association of Great Britain, says more than 2,000 questionnaires have been distributed to members, along with an additional 1,000 to health professionals.

Driven from drink

Denmark is plapping tougher penalties for drunken drivers. Road safety experts meeting in Copenhagen recently suggested the permitted blood alcohol level for drivers of 0.08% should be cut to 0.05% and offenders should be made to spend nights or weekends in prison.

Jailed nurse

A public campaign has been resumed in England to help Rita Nightingale, a 24-year-old British nurse jailed for 20 years in Thailand on heroin smuggling charges. Early in February, the British Foreign Office advised the Portia Trust, a charity, to stop its campaign in case criticism of the Thai courts had an adverse effects on her appeal. After correspondence from Ms Nightingale, however, the campaign has decided to appeal for funds for her legal aid and food in jail.

Wine is big

Nearly two-thirds of Britons beyond 15 years of age drink wine, if only occasionally. Fifty-eight per cent of men and women said they drank wine at home according to the market research journal *Mintel*. Only 6% drank wine in pubs or clubs, while 26% drank it in restaurants. Four per cent of respondents drank wine elsewhere. The survey revealed little difference in wine drinking between the sexes. The typical British wine drinker is 35 to 44 years old, well-to-do, and lives in the south of England.

It's no longer 'normal' to smoke, British reckon

By Alan Massam

LONDON — There is a steady decline of cigarette smoking among adults in Britain despite the fact the government here has not yielded to frequent calls for a ban on cigarette promotion.

Minister of State for Health, Roland Moyle, made this clear at the Western European Workshop on Smoking Control of the Union Internationale Centre le Cancer. (International Union Against Cancer with headquarters at 3, rue du Conseil-General, 1205, Geneva, Switzerland) during a three-day meeting here.

Mr Moyle told the workshop smoking was no longer regarded as a "normal activity" in Britain: when cigarette smokers were recently asked in an opinion poll whether they would like to give up, 68% answered "yes".

"This really is quite an astonishing figure when you consider it. No wonder, in the same poll, almost the same percentage of cigarette smokers (67%) said they approved of further restrictions on smoking in public transport," the minister added.

"This has two messages for us. Firstly, it gives all those who work for a reduction in cigarette smoking the confidence that they are not seriously resisted by public opinion. And second, and more important, it gives us the hope that the tide is really beginning to turn."

Mr Moyle said the British "success rate" had included a steady reduction in the proportion of men who smoke cigarettes and a reversal of the previous upward trend of women cigarette smokers.

There were also signs that for the first time the average smoker was reducing the number of cigarettes he or she smokes — particularly women smoking 20 or more.

Over three years the proportion of adult males smoking cigarettes has been reduced by 4%, and the proportion of women by 2%.

"The message is therefore beginning to reach the heavier smokers; this much is now clear," the minister said.

"Smokers are becoming more and more conscious of the tar content of their cigarettes. One of the most significant trends is the reduction in the average tar yield of cigarettes smoked. In 1972, the average per cigarette smoked was 20.8 mg; in 1977 it had fallen to 16.1 mg.

"Not only is this falling substantially, but it fell at a faster rate last year. About twice as many cigarette smokers now smoke brands in the two lowest tar categories compared with two years ago."

Mr Moyle said this was another encouraging sign that "hard core" smokers were being forced to consider how to reduce the risk to themselves: "We positively take the view in government that persuasion of smokers to reduce their tar and nicotine intakes is a legitimate and essential part of our strategy."

On the question of promotion, the minister said the British government kept an open mind. It recognized that a respectable body of opinion took the view that if cigarette advertising was banned consumption would fall dramatically. But there was "an equally respectable body of opinion" which said the principal effect of advertising was to encourage people to change from one brand to another. The present state of knowledge did not show where the truth lay. That was why the subject would have to be inquired into more deeply.

Mr Moyle said there was great admiration for the quality of anti-smoking measures taken in Norway (which has a total ban on cigarette promotion) but Britain also believed it had had a large influence on smoking. Successive governments here had developed objectives similar to those of the International Union Against Cancer. Health education was seen as the key to ultimate success backed by health warnings and taxation aimed at influencing smoking habits in favor of low tar brands. The introduction of health into the world of taxation was an "important break-through."

The minister concluded: "Lastly, we encourage the rights of the non-smoker and the reduction of smoking opportunities. This is an extremely important element."



Polish vodka is exported to 60 countries, but the beverage is also being consumed at an alarming rate within Poland's borders. (Above) Alcohol Industry Plant at Poznan.

Vodka still plagues Poles

By John Dornberg

MUNICH — Alcohol abuse is a mounting problem in Poland despite numerous government directed anti-drinking efforts, according to quasi-official Polish sources.

Per capita consumption of spirits, for example, rose by more than 100% during a 15-year period (1960-1975) from 2.4 to 5.4 litres, according to *Czas* (Time), a weekly published in the Baltic Sea port city of Gdansk.

Polish industry loses anywhere from 19 to 28 billion zlotys ($575 million to $848 million at the current commercial exchange rate of one US dollar to 33 zlotys) annually as a result of absenteeism, accidents, and shoddy workmanship attributed to alcohol abuse.

More than 85% of industrial accidents and 60% of all violent crimes in Poland are caused by or linked to drinking, according to the magazine.

The government's approach to the problem — similar to that in other Communist countries, notably the Soviet Union — has been to raise the price of liquor, particularly vodka, the Polish favorite, and to reduce points and hours of sale. But the effect has been minimal.

Despite a price increase of almost 300% for a litre of vodka since 1960, from 36 to 110 zlotys (the average statistical income of just under 4,000 zlotys per month) consumption per capita has risen instead of declined.

Drinking at all hours of the day, and even at work, is a pervasive phenomenon in Poland.

During a month's trip through the country last year this correspondent visited scores of government, Communist party, and industrial officials in their offices. Toasts of vodka or brandy — often as early as 9 am — were the rule.

"Our drinking habits," said *Czas*, "seem not to have changed since the 15th centrury. We drink too much and too fast, and often without eating. And there is no drinking without drunkenness."

Organized crime moves into Israel

JERUSALEM — Organized crime has moved into both the hard and soft drug businesses in Israel.

This is stated in a report drawn up by the Shimron Committee, headed by Erwin Shimron, a former state attorney. The committee was set up specifically to investigate charges — until now hotly denied by police — that organized crime had not only invaded Israel but had acquired more than a bridgehead.

The Shimron Report deals with drugs only as a side issue but it is this issue that has attracted most attention.

The report states there are 4,000 "hard" drug (opium, morphine, heroin, medical substitutes) users in Israel and about 10,000 people who use hashish regularly. While the hard drug users fail to function as productive members of society, this is not the case with the hashish users.

(Mr Shimron said there are about 100,000 people, mostly youngsters, who use hashish sporadically but are not psychologically addicted. Between 14% and 19% of youngsters in Israel from 16 to 18 years have tried hashish at least once.)

Mr Shimron said that in the last decade, since about the time the American volunteers for the Six Day War of 1967 introduced hashish as a "western culture symbol", a drug subculture has arisen in Israel. Hashish users always existed but were considered the dregs of society. Now they had become the "elite," he said.

The huge quantities of hashish, and to some extent hard drugs reaching Israel, show the problem has international ramifications, according to the report. This is borne out by the huge sums needed to buy hashish abroad, the smuggling of it into Israel, the wholesaling within Israel, and, finally, the retailing.

Each retailer has his own "area of distribution" protected by strong-arm gangs, which also keep the price up.

What is peculiar to Israel is that there are "almost no pushers in the classical sense trying to snare youngsters." Rather, the users search out the sellers and the shortage has led to soaring prices.

Mr Shimron called for closer cooperation with international law enforcement bodies; closer controls of the ports and airport; and stepped up drug education programs for youngsters.

'It's a most excellent pleasure'

Wine experts judge product

AUCKLAND, NZ — Some specific answers on the question of harmful and beneficial effects of wine were given to the fifth International Oenological Symposium held here.

P. Schumacher, chief surgeon of the district hospital at Breisach, Germany, reported results of research into the effects of alcohol on the liver.

He said the liver of a healthy person weighing 154 pounds would cope with 160 to 200 grams of alcohol in 24 hours (rather more than three bottles of normal table wine). The quantity varied with weight.

But, consumption at this level could not continue indefinitely. If more than 80 grams of alcohol a day were consumed for six years, fatty degeneration of the liver would occur.

In wine terms, that would be a consumption of more than one and one-third bottles of table wine daily.

Fatty degeneration causes tiredness, lack of energy, loss of appetite, irregularities at stool, and repleteness in the right upper abdomen.

However, he said, fatty degeneration and alcoholic hepatitis could be reversed by strict abstention from alcohol. On the other hand, cirrhosis of the liver, caused by consuming alcohol above the limits stated, causes permanent damage.

"In reasonable quantities, alcohol has no deleterious effect on the liver," Dr Schumacher said.

"I consider it to be a positive sin to deprive a chemical factory such as the liver of alcohol, as for example the Moslems do. They not only deprive themselves of one of the most excellent pleasures but also prevent an especially interesting metabolic process taking place in the liver.

"Taken in reasonable quantities, alcohol is a medicament. Even Paracelsus as early as 1537 recognized that: 'All things are poison and not without poison. Only the dose makes a thing not poison'."

New risks to smokers

MOSCOW — Another item has been added to the list of health hazards from smoking.

Nicotine increases the stickiness, or viscosity, of the smoker's blood, slowing the blood supply to the heart and other organs, according to a *Tass* report on work at the Moscow Medical Institute.

The report said this process may prompt an infarction — damage to the heart or other organs — caused by a blood clot, but it did not say whether this syndrome had been observed.

Professor Viktor Lyuzov said it has long been known that smoking was harmful for the central nervous system and blood vessels. Now research had revealed "an additional negative effect in the way nicotine changes the properties of the blood."

He said of all factors causing heart disease, smoking appears to be the most serious.

Greeks ban cigarette ads

ATHENS — Cigarette advertising has been banned from Greek radio and television.

Spyros Doxiades, Greece's social welfare minister ordered the ban in March in the belief it will aid significantly in reducing smoking. He said estimates indicate Greeks are the heaviest smokers in Europe in per capita terms.

Statistics on cigarette consumption rose from 5.1 billion in 1938 to 12.1 billion in 1960, and 20.2 billion in 1976. Greeks beyond age 15 smoked an average of 2,822 cigarettes each or 235.17 cigarettes a month in 1976.

Co-ordinating unit should assist in future

'We've refined our perspective: Dogoloff

(from page 16)

pect and how to channel the treatment experience toward attainable positive goals and not maintain unrealistic and self-defeating expectations. We have realized that heroin addiction is a chronic disease, and that it all too frequently occurs among populations with many other chronic problems and few resources for dealing with them. We know now that the kinds of treatment currently available do not yield a certified "cure" and that the addict is likely to have several experiences in treatment during the course of his career. A long term treatment experience may not be the goal of the client, and thus must be respected. There is evidence that, with each succeeding treatment experience, the addict is likely to be able to sustain socially accepted goals for longer periods of time. So we no longer expect total and immediate abstinence and we do not classify clients as failures at the first incident of recurring drug use. We have redefined success in more realistic terms, using concretely measurable indicators.

And we've learned that treatment works. The initial results of the first long term (national) treatment outcome study are in. NIDA and Texas Christian University have done an evaluation of the outcome of clients admitted to federal treatment from 1969 to 1972 based on data recorded in the National Drug Abuse Reporting Program, unfortunately acronymed DARP, which sounds like something out of Star Wars. The outcome measures used were illicit drug use, alcohol consumption, employment, criminality indicators, and return to drug treatment.

The results of these studies are heartening. Favorable changes are found for most of the criterion measures from pre-DARP baselines to the first year post-DARP, especially among persons in the major DARP treatment modalities — methadone maintenance, therapeutic communities, and drug free. Also, if favorable changes are found in the first year after treatment, they usually continue.

In another area, we have more clearly defined the role of law enforcement — targeting resources at major traffickers and leaving users alone.

We have realized that the most appropriate response to users of narcotics is treatment. We not only offer treatment for anyone who comes in voluntarily, but we try to extract people from the criminal justice system who are more properly treatment candidates. TASC, the Treatment Alternatives to Street Crime Project, was a revolutionary idea when it was first introduced in Washington, DC in 1970. Now TASC has 47 separate programs around the country and processes more than 1,000 new clients a month. TASC offers drug treatment to offenders whose criminal behavior is correlated with drug abuse and whose future criminal behavior and drug abuse may be more properly prevented by treatment, rather than jail.

'The days of the hot shot narcotics officer who arrested large numbers of individuals are over . . .'

And DEA spends its time and efforts going after the big time traffickers — like Nicki Barnes, the heroin kingpin of New York. The case of Nicki Barnes illustrates how the role and methods of law enforcement have changed, and so I'll tell you a little about it.

The Nicki Barnes case began way back in 1974, when a Task Force was formed of state, city, and federal police officers. Intelligence and patience were emphasized from the start. Through painstaking intelligence work, 17 targets were located in Harlem, of whom Nicki Barnes was one. Despite the fact that Nicki Barnes was renowned as the biggest dope dealer in New York, and led a flamboyant life with cars, women, flashy clothes, and a Robin Hood style of giving turkeys and presents to the poor of his old neighborhood around 116th and 8th Avenue, the goal was never just to get Nicki Barnes. The conspiracy case would be made on the network of all 17, and would not be sacrificed just to nail Nicki. *The New York Times* headline read: "Nicki Barnes — Biggest Narcotics Dealer in New York — But Can They Prove It?" illustrated the police problem.

With an enormous expenditure of man hours, the Task Force chipped away at the evidence and gradually they built a case. Nicki Barnes was convicted in a conspiracy case last December — four years after the case began — and got life, with little chance of parole.

All of this demonstrates that the days of the "hot shot" narcotics officer who arrested large numbers of individuals are over. Emphasis now is not on numbers of arrests, but rather on major traffickers. The role of intelligence has vastly increased, and frequently the narcotics officer feels more like a manager handling a complex data system than he does like a police officer.

In the international arena, we have also realized that long term endeavors are more likely to achieve lasting results. We have three vital components to our international efforts:

- To help foreign nations reduce illicit drug production and trafficking;
- To support the efforts of foreign governments as they try to deal with drug problems in their countries; and
- To assist foreign law enforcement agencies with their program of narcotics control.

We don't expect instant results, particularly in the reduction of supply of illicit drug crops. We have learned that simple bans don't work. Instead, we are working in partnership with other countries, with the international financial institutions like the World Bank and with the United Nations to support broad, rural development programs to replace illicit drug crops.

There are four key areas for US action to reduce the international supply of illicit drugs:

- To encourage and support growing of alternative, non-narcotic crops;
- To argue for international economic development programs that support non-narcotic crop programs;
- To assist the foreign governments with efforts to eradicate poppy cultivation in their country; and
- To use the bank disclosure and other financial statutes to reveal and disrupt international money schemes linked to narcotics trafficking.

However, we must remember that the primary responsibility for many of these efforts rests with the governments of other countries. We are asking foreign leadership to help us as partners, and our role thus becomes one of assisting and supporting the leadership of those governments. Drug abuse and the drug problem is not literally an "American disease" as it has been styled in the past, but there *is* a world of difference between our perceptions of heroin, for example, and those of a Thai farmer or a Mexican *campesino*. Our strategy will be to respect those differences, close the gap, and seek international cooperation.

'The simple goal is to reduce the pain and anguish that drug abuse brings to so many individuals . . .'

In summary, our public policy in the field of drug abuse has both broadened and refined over the past 10 years. We have broadened our perspective and have refined our ability to deal with all the elements in it. We have developed a three-part program, with a continuing oversight and coordinating unit which I hope will enable us to respond to the events and public policy problems of the future. But even as I end in discussing broad federal policy, it is important to remember that for me all of this relates back to a simple goal — that of reducing the pain, anguish, and suffering that drug abuse afflicts on so many individuals and families throughout our country.

FDA finds evidence of fraud in drug testing

WASHINGTON — Clinical trials of psychotropics and analgesics have been subject to abuse and fraud among some investigators hired by major pharmaceutical companies to test new drugs.

Evidence of fraud and abuse was presented by Commissioner Donald Kennedy, of the Food and Drug Administration, at a meeting of the Senate health and scientific research committee.

Investigators from the FDA, acting on suspicions of test results in 26 trials, found abuses by 13 doctor investigators.

The drugs under test were produced by major American and international pharmaceutical companies. None of them has reached the market, although some companies were seeking approval for new uses of a product already for sale.

Dr Kennedy told the subcommittee most of the abuses were found in trials of psychotropics and analgesics. He said some of the findings could be viewed as "horrible or inconceivable."

He added it was too early to tell if the "extraordinary, serious abuses" uncovered represent the tip of the iceberg in terms of overall human testing of drugs.

"The great mass of research being conducted is high quality and valid, and the subject participants in most cases are carefully protected," he said.

USAF on drug patrol

WASHINGTON — Giant, radar-equipped United States Air Force planes designed to give early warnings against any surprise Russian fighter attacks, are to be used against drug smugglers along the Mexican border.

The converted 707s of the Airborne Warning and Control System will fly the border between California and Texas ostensibly on flight crew training missions. Also on board will be US customs service agents.

The targets are small light planes used to smuggle heroin and marijuana across the border. Customs officials say most of the flights are at night and pilots hedgehop to avoid radar.

The US Air Force planes have successfully tracked low-flying customs planes during trial runs. Only two planes will be needed in the air at any one time to survey the entire US-Mexican border.

Synanon chairman resigns

BADGER, Ca. — Founder and chairman of Synanon, Charles Dedrich, has resigned his post at the communal drug rehabilitation centre, according to a spokesman for the foundation.

His 27-year-old daughter Jady will now take over as chairwoman of the board.

Mr Dederich, 64, said he wanted to step down because of recent publicity about Synanon lifestyle experiments, including a program called "changing partners" in which most of the society's married couples divorced and found new mates.

A spokesman emphasized this does not mean Mr Dederich is quitting, and he will still be a member of the board.

Synanon has filed a $76.5 million libel suit against *Time* magazine following publication of an article on Synanon.

MDs, dentists cut smoking

ATLANTA — Only 21% of American doctors and 22% of dentists now smoke, according to a study by the Center for Disease Control here.

This represents a significant drop over the past decade: in 1967, 30% of doctors and 34% of dentists were smokers.

There has also been a decline in smoking among the general popnlation. The study finds 34% of American adults now smoke compared to 42% a decade ago.

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barbiturates

factsheet

Barbiturates are the most common examples of a class of drugs known as sedative hypnotics. These are mainly used medically to treat sleeplessness, anxiety, tension, high blood pressure (when combined with anxiety and tension), and illnesses in which there are seizures and convulsions. Barbiturates are also used to produce unconsciousness for short surgical operations or at the beginning of longer operations.

The majority of people who use barbiturates do so on a prescription basis for short periods of time without ill-effects. However, the use of these drugs in larger than prescribed doses, or without medical supervision, may cause serious harm.

APPEARANCE

Sedative hypnotics are white powders sold in capsules or tablets of various colors and sizes. They are also available in liquid preparations (some for injection, others for taking orally) or in suppositories.

EFFECTS

The effects of any drug depend on the amount taken at a time, the past drug experience of the user, the circumstances under which the drug is taken (the place, the feelings of the user, the other people present, whether alcohol or other drugs are taken at the same time, etc), and on the way the drug is taken.

Barbiturates and other sedative hypnotics act as central nervous system (CNS) depressants. CNS depressant drugs tend to slow down or decrease many body functions, such as respiration.

Prescribed doses of short-acting barbiturates (eg, secobarbitol) generally last four to six hours. Barbiturates used in surgery (eg, thiopental) have quick but brief effects. Prescribed doses of longer-acting barbiturates (eg, phenobarbitol) usually last eight to 12 hours, but there may be some grogginess for many hours afterward.

Barbiturates reduce the activity of parts of the brain that make people aware of the outside world; how much this activity is reduced depends on the dose, the person who takes it, and the setting. For instance, a dose that at bed time would produce sleep might produce a 'high' if taken in a social group.

Short term effects are those which appear rapidly after a single dose is taken, and disappear within a few hours or days.
Usually a small sedative hypnotic dose will relieve anxiety and tension, producing calmness and muscular relaxation. A somewhat larger dose produces effects much like those of drunkenness. These may include a high feeling (or irritability and hostility), slurred speech, staggering, and slowed reactions. In a quiet setting, a similar dose usually produces sleep. Much larger doses cause unconsciousness. If enough is taken to stop the functioning of the brain in relation to breathing, the person may die.

Long term effects are those provoked by repeated use over a long period of time.

Regular use of barbiturates induces tolerance — increased dosages are required to produce the same effect. Eventually this process results in physical dependence — a state where withdrawal symptoms are noticeable if drug use is stopped abruptly.

The physical dependence which develops to sedative hypnotics is potentially the most dangerous of all the chemical dependencies. Abrupt withdrawal leads to progressive restlessness, anxiety, irritability — and possibly delirium and convulsions. These symptoms may be life threatening without medical care. Withdrawal is usually managed by a gradual tapering off process.

Long term barbiturate use can result in a 'REM' rebound cycle. (REM is a name for the periods of sleep during which we dream, phases characterized by Rapid Eye Movement). Barbiturates suppress REM sleep — essential for normal functioning. Drug termination leads to a rebound effect where the user experiences too much REM sleep, sleeps poorly, and returns to drug use in a futile attempt to sleep normally.

As tolerance develops and doses increase in order to produce the desired effect (such as sleep), danger to the user increases as well. However, lethal dose levels do not increase substantially with the development of tolerance — a dose that would kill on first usage will also kill an habituated user.

Barbiturates and other CNS depressants (eg, alcohol, tranquillizers, and opiates) increase each other's effects (potentiation). Risk of unconsciousness, respiratory depression, and death increases when CNS depressants are used together. In 1973, 61 people died in Ontario alone as a result of alcohol/barbiturate poisoning.

TOXIC EFFECTS

According to Health and Welfare Canada (Poison Control Program Statistics), sedative hypnotics account for approximately 50% of all reported overdoses of psychoactive drugs. Sedative hypnotic overdoses represent 5% of reported Ontario poisonings due to all substances. Because of the method by which these statistics are gathered, the numbers above may not reflect the full picture of sedative hypnotic adverse reactions.

Accidental overdoses occur when small children eat tablets or capsules as 'candies' and when adults with increased tolerance are unsure how many to take, especially after drinking.

With heavy use of barbiturates, emotional instability is common. In some moods a heavy user may be irritable or quarrelsome. Sometimes a user's mood becomes suicidal. Barbiturates are involved in many suicides and suicide attempts (other drugs may also be involved).

OTHER SEDATIVE HYPNOTICS

Such drugs as glutethimide, methprylon, methaqualone, ethinamate, and ethchlorvynol were introduced as substitutes for barbiturates. It was hoped that these substances would not produce dependence. However, tolerance, dependence, and potentiation can develop with these drugs. Hazards of accidental overuse are similar to those of barbiturates.

WHO USES BARBITURATES?

Use of barbiturates on prescription and in hospitals is common, although Health and Welfare Canada (Bureau of Dangerous Drugs) figures indicate a steady decline in consumption since 1970. One-third more women than men use sedative hypnotics. Data supplied to the Addiction Research Foundation of Ontario from an Ontario prescription service (1973) show that out of every 100 prescriptions filled for men, 14.9 were for sedative hypnotics, as were 23.6 of every 100 prescriptions filled for women. Barbiturates are prescribed most often for people over 50, many of whom have had a serious illness or operation.

Heavy users of some other drugs sometimes turn to barbiturates. Some of these are alcoholics who use barbiturates as a substitute for alcohol, sometimes in an attempt to stay away from alcohol.

However, most overuse of sedative hypnotics is a result of over-prescription. Several ARF research studies show that the potential for addiction is highest among the group of older legal drug users. A small percentage of younger people use barbiturates to produce intoxication.

BARBITURATES AND THE LAW

Barbiturates and other sedative hypnotics are available to consumers only on prescription. These are also restricted at the manufacturing and distribution levels by being available only from firms licenced by the government to deal in them (Schedule G, Food and Drug Act).

Anyone who violates the provisions of the Food and Drug Act by trafficking in Schedule G drugs or possessing them for the purposes of trafficking is guilty of an offence punishable by a maximum penalty of 10 years imprisonment.

The Journal

This page is presented as a service to our readers. The text of the above is available in a smaller format, and can be obtained for minimal cost from: The Marketing Department, Addiction Research Foundation of Ontario, 33 Russell Street, Toronto, Ontario, Canada, M5S 2S1.

Clip this page

New Books

by RON HALL

Applied Research: Impact On Decision Making

. . . by Daniel J. Anderson, Sister Mary Leo Kammeier, and Helen L. Homes

This paper reports the effect of a two-year evaluation study on the "system" employed at the Hazeldon Rehabilitation Center. It is a presentation of some major outcomes of data derived from the applied research and evaluation studies, and an analysis of how the methodologies and outcomes affected the decision-making processes at Hazeldon from 1970 to 1975.

(Hazeldon Literature Department, Box 176, Center City, Minnesota, 55012. 1977. 45p. $3.95.)

The Aetiology Of Psychoactive Substance Abuse

. . . by C. Fazey

A world-wide review of research and literature on publications since 1950, this volume contains three sections which cover the aetiology of alcohol, nicotine, opiate and other psychoactive substance use. In addition to the basic critical analysis of 231 books, articles, reports, and conference proceedings on the subject, the book presents policy recommendations for future research offered by an international group of experts. This is followed by some 2,000 entries covering a variety of theoretical and practical approaches, individual drugs, and countries.

(United Nations Educational, Scientific and Cultural Organization, 7 Place de Fontenoy, 75700 Paris, France. 1977. 238p.)

Drugs In The Classroom: A Conceptual Model For School Programs

. . . by Harold J. Cornacchia, David E. Smith, and David J. Bentel

The focus in this text is on preventive aspects of the drug problem for kindergarten through grade 12, and includes behavioral objectives for drug education. The guidelines which are presented are threefold in nature: education, identification and assistance for drug misusers and abusers, and suggested ways to modify the school atmosphere to make it more conducive to learning. These guidelines come from a review of the latest data available in the literature, an array of school programs in operation, and experiences of federal, state, and local leaders, as well as those of the authors. This second edition has been updated with current statistical data, new program illustrations, references and materials, and additional approaches being used in schools. Subjects covered include: the dilemma faced by the school, pharmacological, psychological, and sociological aspects of drugs, rehabilitation and treatment resources, the law and law enforcement procedures, a conceptual model of the school drug program, and evaluation guidelines and suggestions for use by teachers, administrators, and others.

(C. V. Mosby Company, 11830 Westline Industrial Drive, St Louis, Missouri, 63141. 1978. 2nd edition. 347p. $8.95.)

Other Books

Marihuana Research Findings: 1976 — Petersen, R. C. (ed). US Government Printing Office, Washington, 1977. This volume, NIDA Research Monograph 14, is the more detailed reference report which provided the basis for the shorter sixth edition of the *Marihuana and Health Report*. Epidemiology, chemistry and metabolism, toxicological and pharmacological effects, preclinical effects, learned and unlearned behavior, human effect, genetic and immune systems, therapeutic aspects. Index. References. 251p. $3.

Psychodynamics Of Drug Dependence — Blaine, J.D. and Demetrios, A.J. (eds). US Government Printing Office, Washington, 1977. NIDA Research Monograph 12. Substance abuse from psychoanalytic, developmental and learning perspectives, transference, ego functions, diagnostic and therapeutic research issues. 187p. $2.75.

Alcoholism: Developments, Consequences, And Interventions — Estes, N. J. and Heinemann, M. E. (eds). C.V. Mosby Company, St Louis, 1977. This collection grew out of a course of study in alcoholism nursing. Etiology, epidemiology, diagnosis, dynamics of alcoholic families, pathophysiological effects, problems in children, teenagers, women and their spouses, American Indians and the drinking driver, assessment, counselling, AA and Al-Anon, psychodrama, TA, and sobriety. References. Index. 332p. $10.75.

The Epidemiology Of Heroin And Other Narcotics — Rittenhouse, J. D. US Government Printing Office, Washington, 1977. NIDA Research Monograph 16. Report of the task force on epidemiology of heroin and other narcotics. Estimates of user populations, available methodologies and their limitations, treated prevalence. References. 249p. $3.

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six point scale. For further information, contact Linda Chung, coordinator of the group at (416) 595-6150.

Under The Influence

Subject Heading: Impaired driving.
Details: 26 minutes, 16 mm, color, sound.
Synopsis: Thirty people tested for their high tolerance to alcohol, are chosen by the Los Angeles County Police Department to participate in a driving test. The course is designed to demand quick reflexes, judgement, and control of the car. The subjects first establish a baseline for comparison by driving the course with no alcohol in their blood. Then each subject is given enough alcohol to reach the legal limit in California and drive the course again. All participants feel intoxicated, and most of them are amazed at how poorly they have done.
General Evaluation: Good (4.1). A contemporary and informative film with a clear message, it was deemed an effective teaching aid. The A/V assessment group felt the film could produce attitudes opposed to drug use and help in decision-making regarding drug use.
Recommended Use: Likely to benefit audiences of 15 years of age and older, particularly useful for impaired drivers' courses.

Low Rider

Subject Heading: Impaired driving, youth and alcohol.
Details: 20 minutes, 16 mm, color, sound.
Synopsis: Two young Chicanos decide to buy a car. They spend many hours fixing up the car and take great pride and interest in their new possession. Unfortunately, after a party, one gets drunk and smashes the car. The car is repaired. This time the two youths make a pact that one of them will always remain sober in order to drive home safely.
General Evaluation: Poor to fair (2.4). Although a contemporary film, with a suitable length for most educational uses, it received moderate ratings in other categories such as informativeness, clarity of message, and interest level.
Recommended Use: The film seemed to be designed for general audiences of 15 years of age and older. However, the A/V assessment group felt the film was ethnically oriented and would be of most benefit to Chicano audiences.

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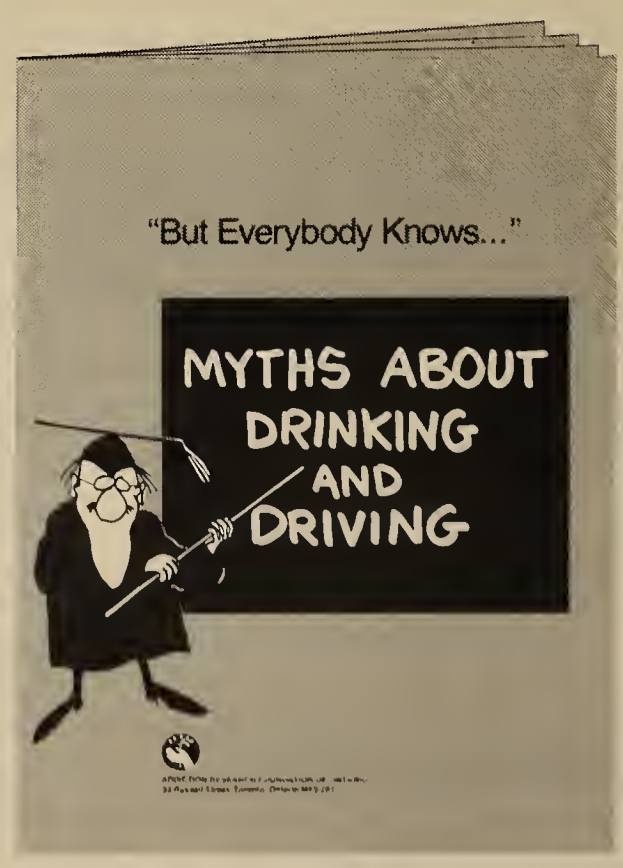
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Coming Events

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Canada

Ontario Medical Association Annual Meeting — May 8-12, 1978, Toronto, Ontario. Information: Dr F.T.H. Porter, 240 St George St, Tor, Ont, M5R 2P4.

125th Annual Meeting Of The American Pharmaceutical Association — May 13-18, 1978, Montreal, Quebec, Information: ADPA, 2215 Constitution Ave NW, Washington DC, 20037.

Canadian Lung Association Annual Meeting — June 12-14, 1978, Winnipeg, Manitoba. Information: Hubert Drouin, executive secretary, Canadian Lung Association, Suite 908, 75 Albert St, Ottawa, Ontario, K1P 5E7.

The College Of Family Physicians Of Canada Annual Meeting — Sept 10-16, 1978, Charlottetown, Prince Edward Island. Information: Donald Rice, executive director, The College Of Family Physicians Of Canada, 4000 Leslie St, Willowdale, Ontario, M2K 2R9.

Alberta Alcoholism And Drug Abuse Commission Summer School On Alcohol And Drugs — Sept 22-23, 1978, Kananaskis, Alta. Information: Marg Bailey, AADAC Community Extension Services, 2nd floor, 812-16th Ave SW, Calgary, Alta, T2R 0T2.

13th Annual Conference Of The Canadian Addictions Foundation — Sept 24-29, 1978, Calgary, Alberta. Information: Stuart Hutton, conference manager, Action Plan '78, 812-16th Ave SW, Calgary, Alta, T2R 0T2.

The College Of Family Physicians Of Canada (Ontario chapter) Annual Meeting — Oct 16-18, 1978, Toronto, Ont. Information: Marcia Barrett, 4000 Leslie St, Willowdale, Ont, M2K 2R9.

Canadian Psychiatric Association Annual Meeting — Oct 18-20, 1978, Halifax, Nova Scotia. Information: Dr A Cote, secretary, Canadian Psychiatric Association, Suite 103, 225 Lisgar St, Ottawa, Ontario, K2P 0C6.

United States

American Psychiatric Association Annual Meeting — May 8-12, 1978, Atlanta, Georgia. Information: Dr M. Sabashin, 1700 18th St NW, Washington DC, 20009.

Nursing Role In Chemical Dependency — May 11-12, 1978, June 8-9, 1978, Center City, Minnesota. Information: Marilyn Brissett, Box 11, Center City, MN, 55012.

Annual Meeting Of The National Association Of State Drug Abuse Program Coordinators And The Council Of State and Territorial Alcoholism Authorities — May 15-18, 1978, Oklahoma City, Oklahoma. Information: Diane G. Tabler, NASDAPC, 1612 K St NW, Washington DC, 20006.

1978 Spring Conference Of The Wisconsin Association On Alcoholism And Other Drug Abuse Inc — May 23-25, 1978, Wausau WI. Information: Don Johnson, conference coordinator, WAAODA, 333 W Mifflin St, Suite 4, Madison, WI, 53703.

Medical Management And Special Problems In The Treatment Of Alcoholism — May 24-25, 1978, Louisville, Kentucky. Information: Office Of Continuing Education, University of Louisville School of Medicine, Health Sciences Center, PO Box 35260, Louisville, KN, 40232.

13th Annual Conference, Association Of Halfway House Alcoholism Programs Of North America Inc — June 4-8, 1978, Minneapolis, Minnesota. Information: Diane Fontaine-Adams, project director, Association Office, 786 E 7th St, St Paul, MN, 55106.

Primary Care Follow-Up And Evaluation — June 5-6, 1978, Center City, Minnesota. Information: Marilyn Brissett, Box 11, Center City, MN, 55012.

The Committee On Problems Of Drug Dependence 40th Annual Scientific Meeting — June 4-6, 1978, Baltimore, Maryland. Information: Joseph V. Brady, professor of behavioral biology, The Johns Hopkins University School Of Medicine, 720 Rutland Ave, Baltimore, MD, 21205.

2nd National Youth Workers Conference — June 7-10, 1978, Washington DC. Information: Arlene Rodenbeck, National Youth Alternatives Project, 1346 Connecticut Ave NW, Washington DC, 20036.

Southern Oregon Institute Of Alcohol Studies — June 11-16, 1978, Salem, OR. Information: Ruthanne Lidman, SOIAS, 3355 View Drive South, Salem, OR.

American Medical Association Annual Meeting — June 17-22, 1978, St Louis, Missouri. Information: James H. Sammons, 535 N Dearborn St, Chicago, Illinois, 60610.

27th Session Of The University Of Utah School On Alcoholism And Other Drug Dependencies — June 18-23, 1978, Salt Lake City, Utah. Information: University of Utah School on Alcoholism And Other Drug Dependencies, PO Box 2604, Salt Lake City, Utah, 84110.

Annual Summer Session Of The Center For Alcohol And Addiction Studies — University of Alaska, Anchorage, 3211 Providence Dr, Anchorage, Alaska, 99504.

Joint Conference Of The American Association For Automotive Medicine And 7th International Association For Accident And Traffic Medicine — July 10-15, 1978, Ann Arbor, Michigan. Information: AAAM executive secretary, PO Box 222, Morton Grove, Illinois, 60053.

1978 Summer Institute On Drug Dependence — Aug 27-Sept 1, Colorado Springs, Col. Information: Summer Institute, PO Box 2172, Colorado Springs, Col, 80901.

Alcohol and Drug Problems Association Of North America Annual Meeting — Sept 24-28, 1978, Seattle, Washington. Information: Lynn Buttorff, executive assistant to director, ADPA, Suite 204, 1101 15th St NW, Washington DC, 20005.

American Association For Automotive Medicine — Oct 3-6, 1978, Louisville, Kentucky. Information: AAAM executive secretary, PO Box 222, Morton Grove, Illinois, 60053.

Abroad

4th International Conference On Alcoholism And Drug Dependence — May 22-26, 1978, Caracas, Venezuela. Information: International Council on Alcohol and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

8th International Institute On The Prevention And Treatment Of Drug Dependence — June 4-9, 1978, Menton, France. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

World Medical Games — June 11-18, 1978, Cannes, France. Information: Le Quotidien du Medecin, 7, Avenue de la Republique, 75011, Paris, France.

International Round Table For The Advancement Of Counselling and 8th International Conference Of Counselling — July 2-6, 1978, Oslo, Norway. Information: Canadian Guidance and Counselling Association, c/o Faculty of Education, University of Ottawa, Ottawa, Ontario.

5th Institute On Drugs, Crime, And Justice In England — July 11-29, 1978, London, Eng. Information: Arnold Trebach, director, Center for the Administration of Justice, The American University, Washington DC, 20016.

19th International Congress Of Applied Psychology — July 30-Aug 5, 1978, Munich, Federal Republic of Germany. Information: Travelaide Ltd, 4450 St Denis St, Montreal, Quebec. H2J

32nd International Congress On Alcoholism And Drug Dependence — Sept 3-8, 1978, Warsaw, Poland. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

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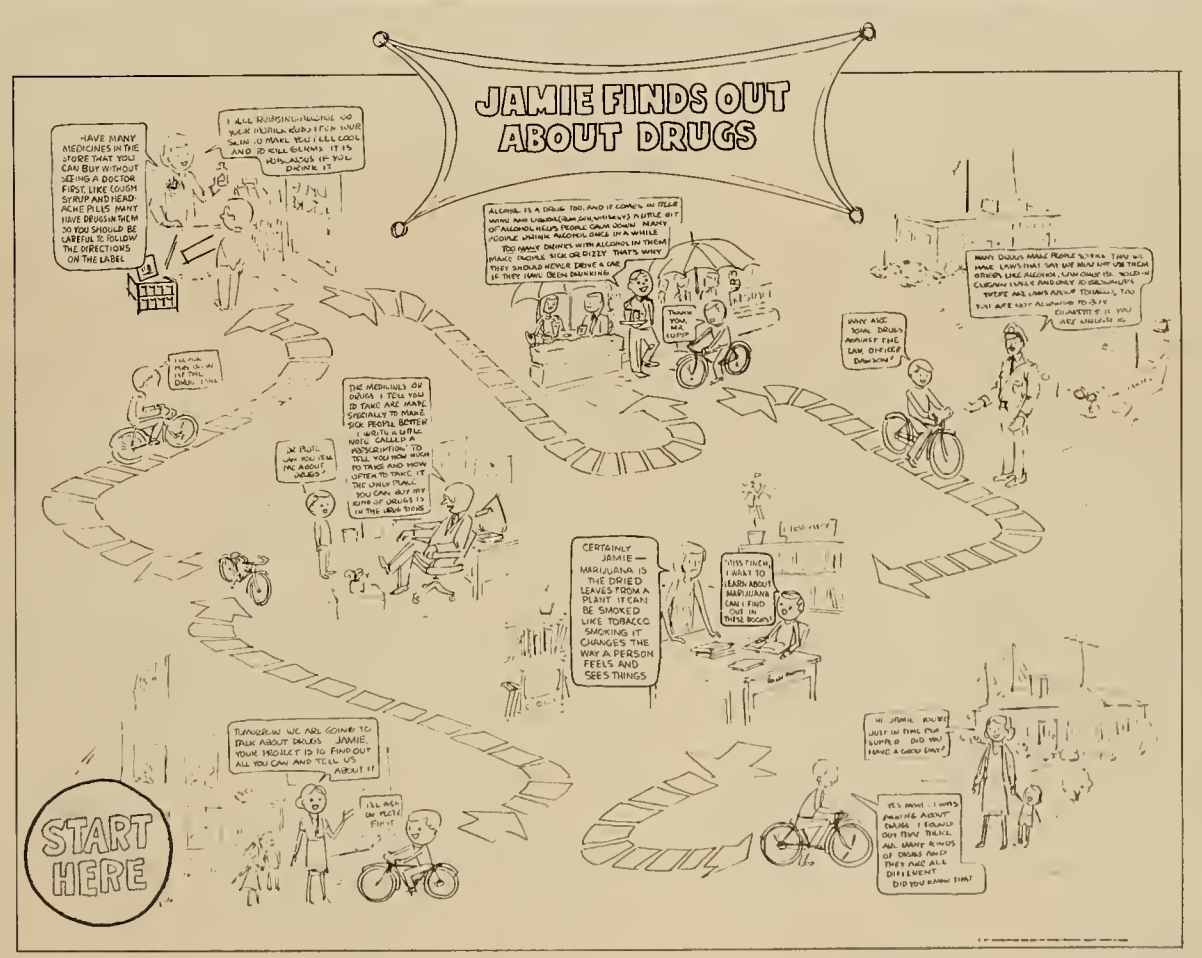
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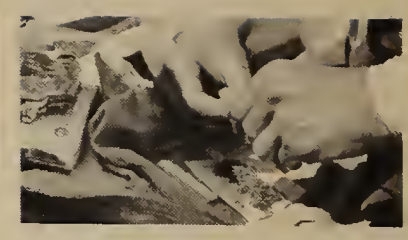
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Drug policies - they're sparked by the times

Although the connection may appear at times to be remote, public policy evolves in response to incidents and pressures of the time, and using the knowledge available at the time," says Lee I. Dogoloff.

Mr Dogoloff, who is associate director of the United States Domestic Policy Staff in the White House, and special assistant to US President Jimmy Carter for drug policy and health issues, has nearly 10 years of experience observing and participating in the forming of drug policy "from all sorts of vantage points."

In this article based on a paper he presented to the National Drug Abuse Conference in Seattle last month, he reminisces about the last decade and recalls what it was like.

By Lee I. Dogoloff

THE YEARS 1969-1970 were filled with incredible unrest, and disturbing events, both bad and good. Apollo II landed on the moon with Americans watching on television; Woodstock happened; the bombing increased in Southeast Asia, and My Lai gave us a glimpse into the dark side of the human spirit; and all around us there were war protests.

I can remember late one night in the Fall of 1969 sitting in the department of corrections in Washington, listening to the reports from the Mayor's Command Center and following police activities. I was trying to figure out what to do with all of the arrested female protestors. We didn't have adequate facilities to deal with the many women prisoners and we had to move our narcotics arrestees out of their cell block to accommodate the women. Burglaries went up in Washington that weekend because the police were occupied elsewhere.



The college students and college-aged young people were not only involved in protesting, they were becoming involved with drugs. Timothy Leary had his marijuana conviction overturned by the Supreme Court in 1969, and the turned-on generation flourished. There were reports of massive, flagrant drug use at Woodstock, with one youth dead of an overdose. *The New York Times* observed that "the dreams of marijuana and rock music that drew 300,000 fans and hippies to the Catskills had little more sanity than the impulses that drive lemmings to march to their deaths in the sea." *The Times* also conducted a survey in 1969 and reported that the use of heroin was growing in our colleges and that "tripping" had become very popular. Meanwhile, Art Linkletter's daughter jumped from a window to her death while on a bad drug trip.

In 1970, I was the deputy director of Washington's Narcotic Treatment Agency, NTA. We used to set up mobile treatment stations on the Mall when there were mass rallies to deal with overdoses and bad trips. During the May Day protest in 1971, we also provided doctors for the crowd of people arrested and interned in the DC Stadium because of lack of other space. I remember during that time talking to a young man who worked with us and who told me that taking heroin in the black community in DC was socially "in" — that the best students, the "leaders," including the football players and athletes, were using heroin. This was very frightening to me.

I felt there were strange currents going on — especially during 1969-1970 — when I saw young people aged 14 or 15 who were using heroin as the first drug they ever tried. But nothing could really match the stark reality of Bruce, a 14-year-old heroin addict enrolled in our program. Bruce took a summer job working in the office next to ours, and when Bruce died of an overdose and I saw our Youth Program doctor crying, all the headlines and statistics took on a new meaning. Unfortunately, Bruce was not to be the last person whom I came to know and later see lost forever to an overdose.

The reports from New York were even worse. *The New York Times* ran a series on addiction in New York, citing 71 teenage deaths from heroin in three months and describing in lurid detail the decay of neighborhoods where, in reaction, vigilante groups roamed the streets beating up addicts. During that time, the Post Office had to spend half a million dollars to send two postmen on certain routes, one to carry the welfare checks, and one to see that the first wasn't attacked. The New York State Narcotics Addiction Control Commission also came under fire. Addicts testified that the commission's program was no more than an expensive prison with sewing classes. Four of the commission's employees were on trial in 1969 on charges of beating up addicts with boots, blackjacks, and handcuffs. Treatment was virtually unknown in 1969.

All of these events and moods formed the backdrop for the development of the last decade's drug policy. There was great concern, laced with a lot of fear, and very little experience in dealing with drug abuse as a national phenomenon. The White House expressed its concern over the "massive escalation in the use of dangerous drugs," and appealed to television and radio to turn the kids around. And then, finally, in early 1971 the reports of heroin addiction among our troops in Vietnam began to drift back and the President was asked in a June news conference:

"Mr President, what are you going to do about the tens of thousands of American soldiers who are coming back from Vietnam with an addiction to heroin?"

In that same June of 1971, the President sent a special message to Congress on drug abuse prevention and control. This message included the first major policy change in my decade of drug abuse experience. In it, the President stated that although Congress had passed his new drug law enforcement legislation in 1970, this alone was not enough. He said: "We must now candidly recognize that the deliberate procedures embodied in present efforts to control drug abuse are not sufficient in themselves. The problem has assumed the dimensions of a national emergency . . . enforcement must be coupled with a rational approach to the reclamation of the drug user himself."

And so, the Special Action Office for Drug Abuse Prevention was created and our previously one-sided policy was transformed into a two-sided one: law enforcement and treatment/prevention.

I can remember, at that early stage, money was not the problem. The problem was what to spend it on, how to gather together the nation's expertise in heroin treatment, how to get communities interested in the "war on heroin — America's public enemy number one." Teams went out from the SAO, trying to get communities to start programs, offering 100% federal financing. At one point, the goal was to establish 12 central intake units nationwide. All of this sounds very strange today, but you must remember the climate was one of a national emergency.

THE BACK PAGE

The next major change in public policy is exemplified by the Turkish Opium Ban of 1972, which demonstrated there were constructive, cooperative initiatives that could be taken internationally to reduce the supply of heroin. The Turkish ban had a temporary, dramatic effect on the heroin supply in our country, but we were not able to follow through in terms of crop or income substitution for the Turkish farmers. Turkey is back growing the opium poppy but harvesting it differently, and that country is not now a source of opium heroin. The ban, however, taught us a lot, and added the third component to our drug abuse prevention and control program, making it drug law enforcement, treatment and prevention, and international control. These three continue to be the components of our drug policy today.

The Turkish ban, combined with the dock strike, produced an east coast heroin shortage which hurled us into the midst of treatment controversies. People were flocking into treatment. I remember at NTA we opened 20 clinics in two years in DC and each clinic filled up within two to three weeks after it opened. Our central unit opened at 9 am and on my way to work each morning at 7 or 7.15 in 1971-72, I'd see 10 to 15 people already lined up.

The controversy over methadone raged. Some addicts testified it was a "miracle," while others warned that young blacks were being systematically programmed into "dependent, sick, criminal wards of the state, governmentally controlled, researched, recorded, and filed in a central registry."

There was rampant paranoia about identifying addicts. In response to this, we actually worked out a system of footprinting at NTA: a photograph of each client's foot served as a unique identification on the assumption that while the police and the FBI might have someone's fingerprint, they were unlikely to have the person's footprint. Although it worked well in Washington, the system was howled down in the national press.

The SAO, in cooperation with what is now NIDA (National Institute On Drug Abuse), got the treatment capacity out to the communities — up to 95,000 federally-funded slots — mostly drug free, but heavily heroin-oriented. We learned about the multi-modality approach and how to link up with the criminal justice system. By 1973, we were operating with three separate fiefdoms; treatment/prevention in the SAO; law enforcement in DEA; and international in the state department. And then, much to our surprise, President Nixon announced on September 11, 1973, that "as a result of this Administration's campaign against dangerous drugs, we have turned the corner on drug addiction in the United States." The President didn't go on to tell us what was around that corner.

SAO went out of business in 1975, leaving NIDA, DEA, and the department of state. This separation highlighted the need for coordination and brought about the next structural innovation in drug policy.

The Office of Drug Abuse Policy was created by the Congress, and activated by President Carter to fill that need. Its functions have now been transferred to the Domestic Policy Staff — which brings us to today. We have seen how, over the past 10 years, a three part drug policy has evolved with an oversight and coordinating unit, growing and responding to the pressures of the last 10 years. What have we learned in those 10 years that will help us in formulating future policies? How have our treatment, our law enforcement, and our international ideas and approaches changed?

In the treatment field we have learned a lot since those first hectic days. We began with a justifiable emphasis on heroin, the drug that caused the most serious individual and social dysfunction. Now, however, we are beyond the "national emergency" mentality, and we have had an opportunity to take a broader look at what we mean by drug abuse and who needs help because of it.

It's personal and social *behavior* that concerns us, and not just the patterns of use peculiar to a particular drug. People who misuse legal drugs, or who suffer harm from legal *or* illegal drugs, run an enormous number of risks and exhibit a grim array of dysfunctions: physical sickness, impaired mental processes; emotional upheaval; a loss of function in the family, job, and community setting; violence; impaired motor skills; psychological and social retardation and a loss of self; criminal activity; and anti-social behavior. And people whose lives are frayed already often lose their lives through heavy drug involvement.

We now recognize that not everyone who uses drugs, or who misuses them, exhibits these characteristics. Some people may use drugs heavily, with no apparent harmful effects. Others may use drugs only occasionally, with disastrous effects.

There is a hierarchy of drug-taking that is helpful in understanding this emphasis on behavior, not just on chemistry.



Millions of Americans take prescription or over-the-counter drugs for therapeutic purposes.

Millions of Americans (but fewer millions) use drugs occasionally for a moderate pleasurable effect.

Fewer still, although still a large number, use drugs occasionally for an intense, powerful psychoactive effect.

Finally, there are a number of people who use drugs compulsively for sustained effect and/or to avoid withdrawing from the drug.

In general, we are trying to look at the health and social consequences of various kinds of drug-taking behavior, including alcohol and tobacco, and to provide treatment when appropriate, or other kinds of intervention when they are called for.

Now we have learned more what to ex-

(See — We've — page 12)

Vol. 7 No. 6 2nd Class Mail Reg No. 2776 TORONTO June 1, 1978

IBRARY ... 1978 Univ... of Toronto

The Journal

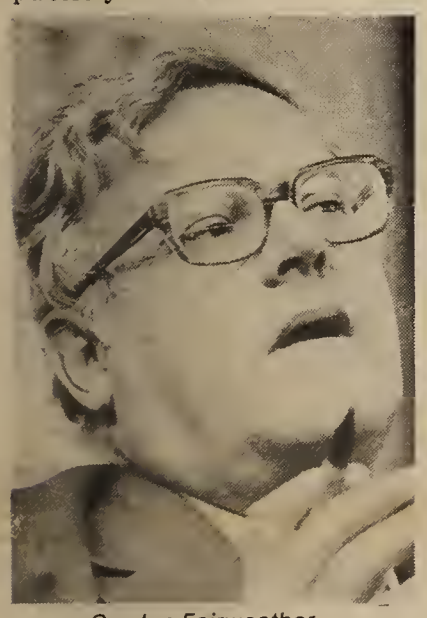
Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

Drug files to be exempt from public scrutiny

Ottawa mum on users and distributors

By Bryne Carruthers

OTTAWA — The federal cabinet has decided to exempt from public scrutiny under the Human Rights Act, all of the information contained in the federal health department's controversial drug user and distributor files. This, despite the fact that much of the information originates from publicly-available records on drug charges and convictions.



Gordon Fairweather

The drug files, reportedly used to generate drug use statistics and to determine the disposition of seized drugs, money, and related goods, cover one of every 100 Canadians.

Of these 200,000 individual drug files, more than 165,000 of the still-secret drug files are on young people known or suspected of using the illegal cannabis drugs, marijuana, and heroin.

Federal health department officials in charge of the drug files defend the action to keep the files secret from even the named individuals, on the grounds that it would not make "bureaucratic sense" to have sensitive information separated from other information, so that some of the information contained in the files could be made available for scrutiny.

Interestingly enough, several other drug-related files, including ones on methadone treatment and others on doctor and pharmacist drug prescribing patterns, are available for review under the Human Rights Act. This is despite internal government legal arguments that even these files should be closed off completely rather than run the risk that some individuals might want to see their complete files, and thereby create administrative difficulties.

The move by cabinet regulation to block any public access to the drug users' files effectively prevents Canadians even from determining whether files on their known or suspected drug habits exist within the federal bureau of dangerous drugs, let alone whether the information contained in the files is accurate.

Thus, the health department appears to be violating the spirit, if not the intent, of one of the basic principles of the Human Rights Act, as identified in a recent speech by Human Rights Commissioner Gordon Fairweather: the protection of the privacy of individuals and their right to access to personal information about themselves.

However, Reid McKim, head of the federal bureau of dangerous drugs and the man in charge of the drug user files, says the files qualify for the blanket exemption under the Human Rights Act because they contain sensitive information and, therefore, the action fulfils the intent of the Act.

Others in the government are not so sure, but admit they are handicapped since they don't know exactly what is contained in the files.

After numerous interviews with involved health department officials, **The Journal** has uncovered areas of potential concern.

For example, the backbone of the drug user file (number 14086 under the privacy index of federal information banks) consists of drug conviction information drawn from public sources. However, once inside the file, the information becomes exempt from any public review, supposedly because the files often contain other, more sensitive information from police and departmental reports, and sometimes from drug treatment centres, doctors, and pharmacists.

More worrisome is the revelation by health department officials that the files can and do contain information on suspected drug use that has been supplied

(See — Drug — page 6)



Ron Basford

Basford proposes diverting addicts before conviction

By Bryne Carruthers

OTTAWA — The federal omnibus bill introduced in Parliament last month would allow judges to send drug addicts for medical treatment, even before they have been found guilty of a crime.

And the crime need not be drug-related.

The amendment to the Criminal Code falls short of compulsory drug addiction treatment: the medical treatment can only be ordered with the consent of both the accused and the proposed treatment facility.

However, it is noteworthy that the change was included in the omnibus bill after discussions with the province of British Columbia, which is planning legislation of its own that could require compulsory treatment for heroin addicts.

(One province, Alberta, now has a compulsory treatment provision under the federal Criminal Code for alcohol abuse in connection with drunken driving charges.)

The federal drug addiction treatment proposal, which might gain Parliamentary approval before the summer recess, is in many ways a first step towards compulsory treatment.

First, a judge can suggest an initial medical examination, to see if the accused is an addict, during a pre-trial hearing and during the regular trial, even though the individual has not been found guilty of any crime.

Consent of the accused is required even for a medical examination; and the doctor's report must normally be submitted within eight days.

If the individual is found to be addicted, the judge may suggest treatment, again requiring the accused's consent and. again, even before the individual has been found guilty of a crime.

If the accused has been found guilty and sentenced, and then agrees to treatment, each day of the medical treatment is to be subtracted from the term of imprisonment.

In either case, the treatment can be offered at a hospital, prison, penitentiary, or "other place where treatment for such addiction is available."

(See — Treatment — page 6)

On European bases

US servicemen are abusing drugs at alarming rate

By Harvey McConnell

WASHINGTON — There is a serious drug abuse problem in the United States armed services but the true extent cannot be gauged unless Congress withdraws its prohibition on random urinalysis testing.

The problem is most acute among personnel stationed in Europe. Fortunately, use is lowest among the 115,000 handchosen personnel who handle all nuclear weapons.

Aggressive action has been taken by US President Jimmy Carter's administration: Peter Bourne, his special assistant for health matters, visited the European command last year; a policy assessment was drawn up by his now defunct Office of Drug Abuse Policy; and Lee Dogoloff, associate director of the domestic policy staff, made a return trip to Europe in February.

Dr Bourne, in a letter to Secretary for Defense Harold Brown, said the reports of rising drug abuse, especially in Western Europe, were alarming.

He added: "We face the potential for serious embarrassment if we do not deal aggressively with this problem." He called on the services to take advantage of new technology for assessing drug use.

At the same time, the administration is pushing Congress to lift its present prohibition on random urinalysis testing.

Testimony to the House of Representatives select committee on narcotic abuse indicates drug use in the Army, Navy, and Air Force has an adverse effect on combat readiness, job performance, and morale.

Almost without exception those who take drugs are in the 18 to 25-year-old range and they indulge primarily when off duty. The most prevalent drugs are cannabis derivatives: marijuana, hashish, and hashish oil.

Patterns differ in various parts of the world. Heroin and methaqualone use is prevalent among Army personnel stationed in West Germany, while amphetamines are the major drug abused on Air Force bases there.

A marked increase in availability of cheap and high quality heroin in recent years in West Germany is a factor in heroin overdose rates for Army personnel. In 1977, the rate was three times higher than the average for American cities.

In Korea, barbiturate use is high. In the US itself, there has been a marked rise in the use of cannabis and PCP.

A poll of 2,350 officers in the three services, and at various stations around the world. was

(See — Availability — page 6)

Inside

- Wayne Howell 2
- Letters to Editor 8
- Backgrounder 9
- Around the World 10
- New Books 14
- Projections 14
- Coming Events 15

Anniversary greetings from Yardley Jones — page 16 —



Donald Smith

Funds to curb trafficking a token of drug abuse costs

NEW YORK — The cost to the world of drug abuse can only be estimated, but it is thousands of times greater than the amount spent on international efforts to curb the illicit traffic.

This means "massive efforts must be made to deal with this problem" through the United Nations, Canada's Donald Smith said at a meeting of the UN Economic and Social Council.

Dr Smith, senior scientist, international health services, Health and Welfare Canada, is first vice-chairman of the UN Commission on Narcotic Drugs and is directing a study on future international action which might be taken in the drug abuse field.

He asked council members to submit suggestions to the study group so a brief paper may be submitted to the commission at its February, 1979 meeting.

Dr Smith said to put the problem into perspective all the costs must be considered.

"These include the cost of drug crimes; the cost of the drugs themselves, which is fantastic, obviously; the cost of detection and prevention of these crimes; the losses from crimes committed to pay for the habit; the cost to the health care system; as well as the efforts in treatment and prevention and the whole apparatus of drug control."

All of this does not take into account the cost in terms of lost and wasted lives.

Dr Smith said: "One guess would be that these costs would be of the order of billions, that is tens of thousands of millions of dollars, which have had to be used on these unproductive tasks, fighting drug abuse on all fronts around the world."

The problem is thousands of times greater than the international effort.

Dr Smith said the UN Fund for Drug Abuse Control (UNFDAC) must be fully and more adequately supported by more sustained contributions.

In addition, "efforts must be made, in accordance with development programs of the countries concerned, giving priority to such projects through aid agencies, both multilateral and bilateral, and in the recipient countries."

Dr Smith said UNFDAC has allowed the beginnings of a concerted attack on all fronts on the social plague of drug abuse, backed by the generosity of nations deeply concerned, both in terms of money, and in cases of countries afflicted by the illicit traffic, also in terms of time and effort.

UN bodies accused of separating alcohol from other drug problems

By Harvey McConnell

NEW YORK — Most United Nations' agencies have made the mistake of separating alcohol abuse from other drug problems, according to Staveros Malafatopoulos of the World Health Organization.

Consideration of problems related to alcohol has been excluded generally from UN attention, he told the United Nations Economic and Social Council meeting here.

In contrast, "alcoholism as a public health problem has always been a concern of the WHO which regards it as a specific type of drug dependence," added Dr Malafatopoulos, director of the liaison office of the WHO.

Few countries are exempt from the problems of alcohol and drug dependence. Drugs that have long been in use in one part of the world are now creating problems in other parts.

He said: "The use of cannabis has spread in Europe and North America while alcohol use is reported to be an increasing problem in India, Pakistan, and Africa.

"Heroin dependence, long considered a problem unique to the large cities of North America, is now a major problem in many Asian countries.

"In those countries where a significant drug problem has not yet emerged, a state of preparedness is recommended because of the high probability that a problem will develop in the near future."

It is WHO policy to encourage countries now considering programs "to put all drug-related problems together with those related to alcohol, in particular when this is connected with multiple drug abuse."

Migration to cities, family instability, erosion of traditional cultural patterns in many communities, which are often associated with social and economic development, contribute to the spread of psychosocial problems, including drug abuse and drug dependence.

Dr Malafatopoulos said provision of services for drug dependent people should, if possible, be integrated with other health, welfare, and economic development programs.

In countries where funds are limited "it is unwise to develop specialized institutions and organizations exclusively for drug dependent patients.

"Even in developed countries with advanced technology, and well developed health and social services, the development of an extensive array of specialized institutions, and organizations sometimes amounting to a service parallel to the existing health and welfare delivery program, is questionable."

The WHO now has requests from Bolivia, Peru, Sierra Leone, and Vietnam for developing programs for prevention and control of drug dependence.

The organization has also two wide-ranging programs under consideration.

Marijuana smokers suffer lung damage

BOSTON — Significant change in lung function has been found by California doctors among 74 men who smoked an average of five marijuana cigarettes a week for at least two years.

The damage was greater than among a matched control group who did not use marijuana, but smoked an average of 16 or more cigarettes a day, according to Donald Tashkin, associate professor of medicine at the University of California, Los Angeles.

He told the American Lung Association meeting here that between 1973 and 1977 lung function studies were made of 74 men aged 21 to 35. They had used marijuana for at least two years and had smoked an average of five marijuana cigarettes a week for the previous six months. Fifty of the marijuana smokers also used tobacco.

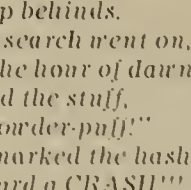
Dr Tashkin said that, on average, lung function was impaired by 25%. This was more marked than among the cigarette smokers.

Dr Tashkin said he does not know if the impairment will lead to clinically significant disease or whether the effects will be permanent. However, it is urgent that long range epidemiological studies be carried out over a period of years.

Dr Tashkin said: "No one should be lulled into a false sense of security that smoking marijuana regularly, at least three time a week, is without any harmful effects on the lungs."

(Meanwhile, in an effort to help Americans identify paraquat-contaminated marijuana, Mexican officials are mixing a red dye with the herbicide before it is sprayed on illegal crops.)

By Wayne Howell



Early in the morning of May 5, 1978, the Quebec Provincial Police and the Hull police raided Le Soleil, a Hull discotheque, with the following results: a single ounce of hashish was found in a purse; a drunk driver demolished the police cruiser that had brought the police to the scene; and three days later seven Ottawa women vowed to seek legal redress because allegedly they had been "indecently probed by a Hull police woman wearing a dirty surgical glove".

Now you simply cannot celebrate police work such as this in prose — the occasion cries out for heroic verse . . . . . .

The Ballad of Le Soleil

They came forth, then, in darkest night,
The men of Law to set things right,
To Le Soleil, a disco spot,
The home of sin and moral rot.
Where youths disported without shame
And danced to music of ill-fame.
And where it was alleged they used
Mind-bending drugs as well as booze.
Into the disco the gumshoes rushed,
Ignoring patrons who were lushed:
'Twas not the demon rum they sought —
Their mission was to find the pot:
No rest 'til all had been disrobed
And every orifice thoroughly probed:
They came to get Respect for Law
From every dancing Travol-ta.
A matron handled the fairer sex
Because the search was more complex:
It's fine police work, nothing shoddy,
This exploration of the body.
Long arms of Law, searching diligent,
With guns at the ready, ever vigilant —
For the Law knows not what it will find
When it goes poking up behinds.
The night grew long, the search went on,
And somewhere near the hour of dawn,
A cry went up, "We found the stuff,
In a purse beneath a powder-puff!"
But as they tagged and marked the hash
From the door they heard a CRASH!!!
Because, you see, an errant boozer
Had smashed into their brand new cruiser,
Buckling bumpers, bending fenders,
And fleeing in a spray of cinders —
Leaving the Law with one ounce of hash
And shards and shards of broken glass:
O Fate, O Fate, what a cruel quirk —
'Twas the cruiser now needing the Body Work!
The moral of this tale seems clear,
Hark now while I state it here!
A noble task, this search for grass
With rubber gloves from ass to ass,
But while the Law is probing bums,
Drunks are making hit and runs.

(Wayne Howell is an Ottawa physician and freelance writer.)

Nerve damage follows dentists' misuse of nitrous oxide

SAN FRANCISCO — A University of California doctor says the misuse of nitrous oxide among dentists is becoming more common, often with disastrous results.

Dr Robert Lazyer, associate professor of neurology at UCSF medical school here reported recently on six cases within a year where dentists had nerve damage due to inhaling "laughing gas" for long periods.

Some of his dentist patients reported using it for periods varying from half an hour to six hours at a time, several times a week.

Most of the dentists took the gas in order to relax, and there was no indication of thrill-seeking, he said.

Dr Lazyer said the dentists sought treatment for a variety of symptoms, mainly a tingling sensation in their feet, numbness in their arms and legs, slowed reflexes, disturbed equilibrium, and the inability to hold their tools in order to work.

His report is the first indicating such problems might follow prolonged use of the agent.

There is no indication short exposure to the gas, such as during dental operations, might be harmful.

The California Dental Association says it's unaware of any widespread problem with nitrous oxide abuse among dentists.

Nervous system toxicity from nitrous oxide has never been reported before, according to the authors.

"We feel that the toxic risks of nitrous oxide need to become more widely known," they reported.

It is widely assumed that nitrous oxide is completely safe and harmless: already the gas has become popular as a recreational drug.

Increase in drug seizures alarming

NEW YORK — Seizures of illicit drugs increased at a frightening rate between 1970 and 1976, and the number of abusers increased six-fold in the same period.

Muzhet Kandemir, assistant director of the UN division of Narcotic Drugs, said the seizures reported by member states represent no more than 5% to 10% of the total traffic in any one drug. He said the figures are:

- 30 tons of opium were seized in 1970; 50 tons in 1976.
- 650 kilos of heroin were seized in 1970; 2½ tons in 1976.
- 460 kilos of cocaine were seized in 1970; two tons in 1976.
- Half a ton of liquid cannabis, which was not produced by traffickers until 1971, was seized in 1976.

Mr Kandemir said some of the countries hardest hit by drug abuse are among the least developed in the world.

Countries in Africa are now receiving special attention from the division and a detailed study of the drug control needs of many has been completed. Assistance has been given to provide basic laboratory equipment and to train law enforcement officers.

HEW chief appoints Loren Archer as acting director of NIAAA



Ernest Noble

WASHINGTON — Loren Archer, former director of alcohol programs for the state of California, has been appointed acting director of the National Institute on Alcohol Abuse and Alcoholism.

He replaces Ernest Noble, who was dismissed from the post by Joseph Califano, secretary for health, education and welfare.

Mr Archer came to Washington last year and has been carrying out special studies for Dr Noble and HEW prior to his appointment. He is the first NIAAA director who is not a doctor of medicine.

Mr Archer's appointment has been received favorably by many officials in the field. It is pointed out that he is well known in the states and has had experience at local level in dealing with clients.

Dr Noble, who is on leave from the University of California, Irvine, will remain in Washington for several months to survey prevention studies of the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) institutes.

Mr Califano has also told Robert DuPont, director of the National Institute on Drug Abuse, to find a new job. When he departs, Mr Califano will have cleaned house at ADAMHA: in December he dismissed Bertram Brown as head of the National Institute on Mental Health.

Dr DuPont indicated he will not leave NIDA immediately, but does not intend to remain for a very long period.

As a career government employee, Dr DuPont has tenure within the system and, in his position, must be given an opportunity to find another placement.

California extends 'bartenders' rule

Host liable for drunken guest's car accident

By David Milne

SACRAMENTO — The California State Supreme Court has ruled a host can be held liable for third party damages if a drunk guest later becomes involved in an accident.

The court ruled six to one in favor of the new decision which extends California's 1971 "bartenders" ruling to include private social gatherings.

The ruling makes any social host liable who provides alcohol to an intoxicated guest under conditions that would probably lead to risk of harm to others.

Under the old ruling, if a bartender served an individual who was obviously drunk, and who went out subsequently and injured somebody, the victim could sue the bar.

The court extended the meaning of "person" in the old ruling to include "anyone who sells, furnishes, gives, or causes to be sold, furnished, or given away, any alcoholic beverage to . . . any obviously intoxicated person is guilty of a misdemeanor."

The ruling rose out of a case in which a young man was left almost completely paralyzed, mute, and impotent after the car in which he was a passenger crashed.

The man sued the driver of the car, the manager, and owner of an apartment complex where the driver had been drinking, and the owners of a bar.

The petitioner's lawyer argued the defendants knew that the driver who had formerly worked at the apartment complex and customarily drank to excess, intended to drive.

Consequently, he argued, the defendants knew or should have known that their conduct would expose third persons to foreseeable risks or harm.

The blood alcohol test of the driver was well in excess of the legal limit.

The suit is asking $1 million damages from the apartment manager and the apartment complex owner. Other litigation against the driver and the owners of a bar where she also drank, was settled out of court.

The manager and apartment building owners demurred to the damage suit on the grounds that they had no liability, and they were upheld by a county Superior Court. This was overturned, however, by the state Supreme Court.

UK testing Canadian technique to help identify drinking drivers

By Alan Massam

CRANFIELD, ENG — The British Government is studying a method devised by two Canadian psychologists which could significantly reduce drink-impaired driving on roads.

Tests so far at an isolated airfield here have shown the method successfully identifies drivers with even a modest (below the legal limit) blood alcohol content.

Essentially the method is of value because of its simplicity. If adopted, motorists would be required by law to perform a simple driving test involving them in correctly aligning their cars at a predetermined speed. Those who fail the test — detected electronically — would be subsequently stopped by police to undergo standard tests for blood alcohol content.



The road test consists of pneumatic tubes clipped to the road surface in such a way that they signal impact of the driver's front tire wheels. White parallel lines are painted as a lane leading up to the tubes for a short distance. The method, therefore, tests a motorist's ability to keep between the lines in the same way that police used to check drunks by asking them to walk along a white line.

The technique is the brainchild of Dr Barry Bragg and Dr W. Taylor Wilson, and has already been evaluated by the Canadian Department of Transport's road safety branch.

It is estimated that in Britain 5% of drivers at night are legally impaired by drink, while 45% have a blood alcohol level below the legal limit. This means that random checking of night-time drivers by police would only "find" one drunken motorist in every 20 detained. Previous studies have shown that visual assessment of motoring performance is a notoriously unreliable approach to spotting the drink-impaired driver.

The introduction of the Bragg-Wilson method, however, would mean that one in every two drivers stopped by police would be legally drink-impaired.

Dr Bragg told **The Journal**: "Preliminary tests with this device suggest that the police could detect 50 impaired drivers for every 100 stopped. Of the 50 non-legally-impaired drivers, 45 would have been drinking while only five would be sober. This device would therefore increase the efficiency of the police while reducing markedly the bother to sober drivers. In addition, it should be noted that the skill of drivers in our tests who had below the legal limit of blood alcohol was almost as affected as that of the drivers who had above the legal limit (80 mg%).

The experiments involved the participating drivers consuming carefully measured amounts of vodka and orange in order to reach predetermined levels of impairment (50mg%, 100mg% or sober). Each of the participants drove through the test course 10 times on three different nights with a different degree of impairment or sobriety.

Cranfield Institute of Technology, Cranfield, Bedford, England, MK430AL.

Overdose fatalities decline

WASHINGTON — Narcotic overdose deaths in the United States dropped an estimated 39% in 1977, a survey of 24 metropolitan areas has shown.

A major reason given for the decline is the success of the American efforts to stem the flow of heroin from Mexico.

Drug Enforcement Administration officials said street purity of heroin has dropped to 5%, the lowest ever recorded. At the same time, the price of street heroin has climbed to $1.70 a milligram, the highest price yet for the drug

Ban on opium crops hurts Afghan farmers

NEW YORK — Severe local hardship has been created in parts of Afghanistan where opium poppy cultivation has been banned.

Abdul Hamid Aziz said while a great number of factors are involved, the reality is "opium is the only cash crop and principal means of livelihood for these people."

He told the United Nations Economic and Social Council meeting here coherent efforts are being made through various UN agencies to develop the social and economic structure of the drug producing regions in order to stop illicit opium production.

At the moment, however, "the banning of opium poppy cultivation in those parts of Afghanistan which are traditional producers of opium has created serious local hardship."

Mr Aziz pointed out that in his country "while there are substitute crops that would earn good income per unit of labor, there are almost no crops that will earn more than illicit opium per unit of land." Some form of farming subsidy is needed.

Another priority is building of roads in the rugged terrain where the poppy is cultivated.

In spite of the fact that Afghanistan, as one of the least developed countries, has had other priorities, it appreciates its international obligations "and we have never been lax in enforcing measures to promote, at its best, the control of narcotic drugs," Mr Aziz said.

But, Mr Aziz warned, "I should make it clear, with due honesty, that a total elimination of illicit drug production cannot be achieved in Afghanistan without foreign financial and technical assistance."

Afghanistan is also a transit route for opium coming from the East. The government has intensified police training, and strides have been made in trying to control this traffic.

(Since Mr Aziz spoke a revolutionary government has seized control in Afghanistan.)

J678

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NB study exposes myths about women alcoholics

By Edith Robb

MONCTON — A research project here reveals a new image of the female alcoholic in New Brunswick.

She's not, as songs and stories picture her, some middle-aged mama boozing it up at a local bar. She's not usually a victim of lack of education or money either.

Rather, the woman is probably about 35 years of age, has had an education exceeding Grade 12, works outside of her home, and spends long, lonely, guilt-ridden evenings drinking in the privacy of her home.

Often she has suicidal thoughts, and sometimes she actually attempts to end her own life. She experiences dizziness, blackouts, and other symptoms of addiction.

Generally, she has happy memories of her home life, but shudders when she recalls her adolescence. She was likely brought up in the city, her feelings towards her brothers or sisters are likely inconsistent or poor.

In most cases, her drinking habit has brought financial difficulty upon her family.

The study covered 302 women selected at random from electoral lists. As well, several service clubs and law enforcement agencies were contacted by the researchers. The study was funded by the federal government's Non-Medical Use of Drugs Directorate, and conducted by Billie Thurston of the Moncton Alcoholism Program Centre, and Gail Walsh of the Bathurst Detoxification Centre.

Ms Thurston: "Our objective was to determine if there were any real female alcoholics in this province. Before we could plan treatment programs or possible solutions, we had to determine just what sort of problem existed. Up to this point there has been surprisingly little research into the problem of female alcoholism in Canada, and none at all in New Brunswick."

The researchers found the female alcoholic is less visible than her male counterpart.

"Traditionally, women tend to be more isolated from public view than men. And even when they're out in the work force, often their male bosses give them a sort of paternalistic protection and cover up for them. Women at home are protected by their families who fear the stigma of alcoholism. As result of this, many women do not get treatment when they really need it."

Of the 302 women interviewed, 19% were found to have abused alcohol or other drugs. The basis for determining addiction was in three parts: the women's consumption over a certain minimal level, an indication that the woman had withdrawal symptoms, and an indication that the woman's drinking problem had affected her lifestyle.

The study found also that when women did seek help in New Brunswick, many did not receive any satisfaction. A common complaint was that the agencies purporting to offer assistance, continually were putting each other down.

"The main factor with regard to treatment in New Brunswick is the near absence of specific detoxification treatment centres," added Ms Thurston. "In the entire province there are only five detoxification beds and 10 rehabilitation beds for women alcoholics.

"The fact that these beds have not had a high occupancy rate is often used as an argument that no more are needed," said the researcher, "but we do need more treatment facilities. The question we have to answer is just what kind will deal with the problem most efficiently."

The study concluded with recommendations suggesting more research in all areas of female alcoholism be conducted, that the public and health professionals be better educated on the subject, that employers should check their alcoholism assistance program to make sure they also deal with women, and the entire question of required treatment be studied.

They stressed early identification of alcoholism in both men and women as a means of prevention of serious problems later, and expressed concern over what they felt was the excess prescription by doctors of mood-modifying drugs to women.

Cancer patient's drug dependence differs from 'normal' addictions

By Jean McCann

HOUSTON — The word "addiction" should not be used in conjunction with narcotic drug use by cancer patients.

"They can become physically dependent, but they're not addicted", Kathleen M. Foley said here. Dr Foley equates the term addiction with the craving of a street addict for a drug, not with the legitimate tolerance acquired in order to achieve pain relief.

"Both tolerance and physical dependence occur with chronic narcotic administration, but these states are separate from addiction, a state in which there is a concomitant behavioral pattern of drug use with an overwhelming involvement with the use of the drug, and securing its supply," said Dr Foley. She is assistant professor of neurology, Cornell University Medical College and coordinator of the pain program, department of neurology, Memorial Hospital for Cancer and Allied Diseases, New York.

This confusion over the term addiction has been to the detriment of the cancer patient, because doctors think of "physical dependence" and "addiction" as interchangeable terms, and are reluctant to give the cancer patient the amount of pain relief needed.

Physicians are also generally ignorant of the pharmacokinetics of narcotic drugs, and are further inhibited by drug laws. These call doctors and pharmacists to strict account over amounts prescribed.

This combination of factors, she said, has meant inadequate pain relief for most cancer patients.

In contrast with the general situation, Dr Foley said that at the Memorial Sloan-Kettering Cancer Center, 33% of patients in a recent study required analgesic drugs to control their pain, with narcotic analgesics being the most commonly-used kind. This has brought adequate pain relief to from 90% to 95% of patients.

Morphine is commonly used, she added, but now the center has also received a grant to study if heroin is any better at providing pain relief. This study will run a year and involve about 40 patients, and was based on the success stories from England, where heroin is a component of the "Brompton cocktail" used for cancer pain relief.

Dr Foley said at Memorial Hospital, patients are placed on a pain regimen while in hospital, and given appropriate quantities of drugs upon discharge.

"Over the last three years, we have had no patient with cancer, who when discharged from the hospital with chronic pain on narcotic drugs, has attempted suicide using the prescribed drugs. Neither has any member of a patient's family attempted to use these drugs abusively."

A pilot study in-hospital has shown cancer patients can successively self-administer narcotic drugs.

"Their pain medications are kept at their bedside, and the patients take them on a regular basis, noting the time and amount. At eight-hour intervals, a new supply of medication is delivered to the patient. This method has allowed these patients to become autonomous from the nursing staff in this aspect of their care."

Dr Foley said the narcotic regimens are also adjusted so patients are still alert, and able to communicate with family and friends. In some instances, they've been able to continue working.

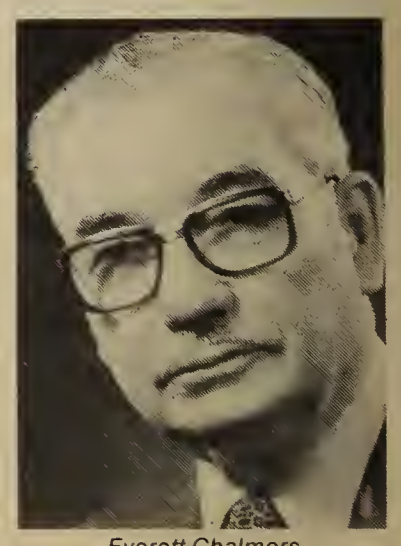
(Dr Foley was addressing a seminar of science writers sponsored by the American Cancer Society.)



Kathleen Foley

Chalmers draws fire for speech on women

By John Carroll



Everett Chalmers

FREDERICTON — Controversy continues to swirl around Everett Chalmers, chairman-designate of the New Brunswick Alcoholism and Drug Dependency Commission.

At the time of his appointment as minister without portfolio, with special responsibility for the ADDC, Dr Chalmers' ability to provide proper services to the province's Francophone population was questioned by news reporters who recalled his opposition to New Brunswick's Official Languages Act.

Within a few weeks of his appointment, the elimination of the position of executive director of the alcoholism program of the department of health (held by Arthur Young) triggered resignations on the part of regional coordinating staff.

The latest uproar stems from remarks made by Dr Chalmers in an address to the New Brunswick Council on Smoking and Health. At the Saint John meeting, Dr Chalmers said: "I think women were brought into the world to bear children . . . any woman who decides somewhere along the line that she wants to make a life's career, that's all right, but let her forget the marriage ceremony and go out and do her bit.

"If she wants to raise children . . . I think it's her duty to stay at home."

Dr Chalmers suggested women's liberation and the decay of the family unit were linked to juvenile delinquency. And he argued that a career for a woman was acceptable only if it did not interfere with the normal development of her child.

In subsequent interviews, Dr Chalmers said he based his views on his observation as a practising physician of 45 years' standing. He said: "Women who want to bear children should stay home with them until they are at least eight-years-old. This is the time during which the child needs the most security. A child should have someone he can count on seeing every day, someone that he can get attached to — not a string of different baby sitters, or housekeepers, or day care centres.

"When this is the situation, we find the youngsters looking for security elsewhere — often in gangs, though sometimes with church organizations or activities."

His remarks prompted an angry response from Madeleine LeBlanc, chairman of the New Brunswick Advisory Council on the Status of Women. Mrs LeBlanc, a working mother herself, said she was disgusted with Dr Chalmers' "out-dated, narrow-minded attitude." She said most working mothers do so out of need, with many not being in the labor force from choice.

Mrs LeBlanc questioned whether female alcoholics would receive help from the ADDC because of Dr Chalmers' attitude. Noting the increasing number of female alcoholics in New Brunswick, Mrs LeBlanc wondered whether such women could expect a fair deal from a man of Dr Chalmers' outlook.

The views of Dr Chalmers are in basic conflict with findings of a study funded by the federal government's Non-Medical Use of Drugs Directorate and carried out in New Brunswick in the summer of 1977. It reported that one of the reasons homemakers swell the ranks of female alcoholics is because some of them are resentful underneath the surface of the roles imposed on them. Women at home have more time to drink and in the case of affluence, have more money to buy more and better liquor. For them, drinking relieves pressure, boredom and frustration.

In July, 1977, the Canadian Addictions Foundation, meeting in Winnipeg, was told social pressures — including male chauvinism — were driving an increasing number of women to drink.

Teacher loses job over paraquat memo

SILVER SPRING, MD — A high school teacher has been suspended by Montgomery County education officials for giving her students a mimeographed sheet containing the name and address of a California laboratory where marijuana may be sent for paraquat testing.

Officials said the action violated school board policy which prohibits teachers from doing anything which condones or encourages drug use. The teacher, who has been at the school seven years, engaged a lawyer from the American Civil Liberties Union.

Sex therapy benefits recovering alcoholic

By Jean McCann

ST LOUIS — Sex therapy is an important part of recovery for an alcoholic and should begin about three months after initial treatment is completed, Janet L. Dowsling told the annual meeting here of the National Council on Alcoholism.

"In the first three months of recovery, the patient already has a multitude of physical, mental, and emotional changes and adjustments to deal with," said Dr Dowsling, co-ordinator of medical services, The Donwood Institute, Toronto.

"There is also the chance that in the first three months of recovery, the basic sexual dysfunction will have begun to heal itself.

"However, if sexual dysfunction is still a major concern for the patient or his partner by the end of three months, sex therapy is appropriate."

Dr Dowsling said sex therapy should not be given, unless the recovering alcoholic requests it. Ordinarily, it can be accomplished in a period of three to six months.

It fits into the realm of therapy in general, and failure to solve sexual problems will inhibit recovery as a whole, she said.

"In our experience, most recovering alcoholics who complain of a sexual dysfunction do not have a clear-cut organic basis for their problem. Certainly they have been exposed to a powerful depressant that has controlled their thoughts and actions, and generally put a damper on their sexual interest."

This means that the sexual lines of communication with the spouse have to be restored along with general communication.

"Learning to deal with one's sexuality can be an important step in creating a new, more confident self who can learn to cope in a chemical-free world. Sex therapy for recovering alcoholics offers an excellent opportunity to begin building self-esteem, which is an initial step in rebuilding lifestyle that has been grossly damaged by alcohol. It can serve as a unifying force for a couple that has not had the experience of working together as a loving team for quite some time, and it can reinforce sobriety."

Working with the alcoholic and spouse, the first step is to assess the sexual problem, including any possible physical or drug-related causes. This begins with a detailed sexual dysfunction history, and includes a description of the current problem by both partners. "Don't be surprised if it sounds as though they don't know each other," Dr Dowsling cautioned.

Both partners should be asked what they feel has caused the problem, and what their goals are in therapy, so treatment may be directed toward this.

It must be remembered, Dr Dowsling said, that the cause of dysfunction "may be related to the drug itself, to alcohol-related disease, or to psychological causes".

In women, sexual dysfunctions include general sexual dysfunction or inhibition of general arousal; inability to achieve orgasms; vaginismus, a spastic condition of the vagina which prohibits entrance of the penis.

"For the recovering alcoholic woman, general sexual dysfunction is a common complaint," she said, "and this may be due either to the depressive drug, or to the devastating depression that is usually her lot."

To treat this, she suggested the Masters and Johnson technique of forbidding intercourse and instructing the couple in "pleasuring exercises" in which they gently touch and kiss each other,



Janet Dowsling

while getting in touch with the sensations involved. Gradually, genital stimulation is added to these 15-minute sessions and, finally, non-demand coitus, which is usually in the female superior position, with stress on her directing the lovemaking.

In orgasmic dysfunction, Dr Dowsling said, masturbation may help in achieving the goal of orgasm. With vaginismus, the spastic vagina can be desensitized by gentle insertion of fingers, tampons, or dilators. Muscle relaxation, and fantasy, may also help desensitize the phobic element in this relatively rare condition.

Sexual dysfunctions of the male include erective and orgasmic dysfunction. The alcoholic man often has a pattern of impotence, or erectile failure, and to this is added his fear of failure and associated depression.

"Sexual tasks are assigned in a graded fashion to create non-demanding sexual ambience, to enhance and extend sexual expression, and to facilitate the removal of anxiety and hostility. Coitus is often best first attempted in a female superior, non-thrust position, progressing to a more active male role. Rarely, when a specific deficiency is demonstrated, testosterone may be of help."

Dr Dowsling said it is important, in any dysfunction, not to give up simply because there may also be a physical cause.

Most commonly, "sexual function is only partially impaired by diabetes, neurological damage, antihypertensive medication, or advanced age. However, the patient's alarmed or discouraged response to partial impairment and the partner's response, may then produce complete dysfunction by virtue of these emotional reactions. While sex therapy obviously cannot alter the underlying illness, it is highly effective in dispelling reactive performance anxiety. For this reason, a medical diagnosis of a disease which impairs the sexual response, such as diabetes, does not rule out sex therapy for the patient."

A tally must be made also of any drugs the patient may be on, because they have variable effects on sexual response, and they include some of the medications to which the recovering alcoholic may well be exposed.

Treatment is completely drug free

UK centre for alcoholics claims 78% success

By Alan Massam

LIVERPOOL, ENG — A group of industrialists in the West of England are backing a unique alcoholic treatment centre which is claiming a 78% success rate in the treatment and rehabilitation of patients in a trial which lasted 2½ years.

This impressive claim was made by the centre's director, Philip Golding, at the 4th International Conference on Alcoholism here.

He told delegates that 64 patients who had passed through the unit — Broadway Lodge in the seaside town of Weston-Super-Mare — had been assessed by questionnaires to the patients themselves, relatives, and family doctors. Thirty-six of the patients were men and 28 women "thus giving the lie to the frequent claim that alcoholism is largely a male preserve," Dr Golding said.

About 90% of the patients were also abusing tranquillizers or hypnotics or starting treatment and only seven had not had previous treatment elsewhere for alcoholism.

Dr Golding said the Broadway Lodge technique was based on methods developed at the Hazelden Foundation in Minnesota, USA. Its counsellors had been specially trained in the US and constituted a "highly effective team."

Treatment was entirely drug-free and involved the patient being made aware of his illness and taking responsibility for his own recovery.

"The results of our survey, together with the increasing number of alcoholics being referred to us since the survey period, demonstrates that the National Health Service facilities for treating alcoholism are far below those required both in quality and quantity," Dr Golding said.

"Furthermore, it is worth noting that many of the patients involved in the survey had frequently been admitted as in-patients at NHS hospitals where it had been suggested to them that they could return to normal drinking on discharge.

"We at Broadway Lodge are convinced that the correct goal in treating alcoholics is that of complete abstinence not only from alcohol but from the mood-altering drugs such as hypnotics and tranquillizers.

"It has been said at this conference that 80% of general practitioners do not consider alcoholics worth treating. It should be pointed out that psychiatrists, who treat the vast majority of alcoholics on the National Health Service, do not have either the proper training, the time, the facilities, or the interest to treat alcoholics adequately."

Intake of alcohol enhances susceptibility to food allergies

By Dorothy Trainor

OTTAWA — Food allergies are aggravated by alcohol, according to Missouri investigator George A. Ulett.

"Our research began with a look at food allergy in alcoholics. We were intrigued by the many alcoholics who told us they were 'allergic' to alcohol," Dr Ulett, director of neuropsychiatric services, Deaconess Hospital, St Louis, told the Group-Without-A-Name Psychiatric Research Society meeting here.

Dr Ulett and his team then learned of the cytotoxic food test used by St Louis colleagues William and Marian Bryan. Using the cytotoxic test, they determined food allergy with respect to 70 foods. The subjects were 25 male alcoholics, 25 volunteer controls, and 25 Alcoholics Anonymous members who had been abstinent for a minimum of six months.

"Alcoholics showed roughly twice the amount of food allergy seen in either the control orAA subjects, and their results were all significant," Dr Ulett said.

In the cytotoxic test, 8cc of blood is taken from the fasting patient. This blood sample is centrifuged, diluted, and mixed with separate samples of food allergens. The white cell/allergen mixture is observed under the microscope after two hours.

"Because there was a notable difference between the drinking alcoholics and the non-drinking alcoholics (AA group), it was clear that the higher food sensitivity was not something characteristic of persons who become alcoholics. Rather it was related in some way to the recent use of alcohol. This seemed further evidenced by the fact that the control group containing social drinkers had more allergy than the AA group who did not drink at all."

The major conclusion of this study, Dr Ulett said, is that food allergies are enhanced by the intake of alcohol.

In a second investigation using cytotoxic testing, coffee-sensitive subjects who drank two cups of coffee showed prompt increases in white blood count, and increasing amounts of coffee increased the WBC in a typical dose-response fashion. Also, in tobacco-sensitive subjects who smoked two king-size filter cigarettes, an increase in WBC occurred. Subjects who were not sensitive to tobacco, similarly exposed, showed no such response.

Another point discussed by Dr Ulett concerned the concept of "masked" food allergy which, it has been suggested, can explain both chronic alcoholism and addiction to caffeine. In this masked allergy, after ingestion of the food, an occasional ill effect might be noted at first, but later one goes on to a feeling of "pick-up" after a meal in which the food is eaten. Finally, more frequent and larger doses are needed to provide the same level of alertness until, finally, adaptive mechanisms are exhausted.

"Severe depression with suicidal attempt, migraine-type headaches with nausea and vomiting, hyperactivity and impulsive behavior, retro-orbital pain, lack of energy, weakness, and anorexia, migratory arthritis and sleep disturbances — these are some of the myriad symptoms related to specific food sensitivities seen in our patients. Many have improved markedly on diets eliminating these foods to which they reacted positively on cytotoxic testing."

However, Dr. Ulett said allergies rest on what he called "the tripod of heredity, emotion, and specific allergen.

"The intensity of allergic reactions depends upon the amount contributed by each leg of the tripod and, in addition, there is always the compounding of allergens," he said.

Mandatory sobriety tests urged for private pilots

WASHINGTON — Private pilots suspected of being drunk should be required to submit to mandatory sobriety tests, says a United States congressional study.

If the pilots refuse to take a test then their licence to fly should be suspended. This is one of the major recommendations in the report by the General Accounting Office, the congressional auditors, following a study of the problem.

It was found that over an 11-year period, 1964 to 1975, alcohol caused, or at least contributed to, 485 accidents involving private planes. At least one person was killed in all but 50 of the accidents.

Over the same period, use of alcohol was not involved in any accident of a commercial airliner.

The GAO report says federal safeguards against drunken pilots are weaker than those the states have for drunken drivers. In every state, failure to submit to a sobriety test means licence revocation.

The legal aspect of applying sobriety tests for private pilots is now under consideration by the Federal Aviation Administration.

Edward Scott, assistant secretary of transport, says "consideration will be given to the appropriate federal role" in seeking cooperation from various law enforcement agencies which would have to carry out sobriety tests.

Synthetic cocaine not illegal

FAIRFAX, VA — A claim that the cocaine he sold a police undercover agent was the rare synthetic variety, and not derived from coca leaves, has saved a Virginia man from going to jail.

Three counts of cocaine distribution were dismissed by a county court judge after defense attorneys claimed the prosecution had not proven scientifically the cocaine was illegal.

Under Virginia law, cocaine derived from coca leaves is illegal. Synthetic cocaine is simply not mentioned.

An official of the Drug Enforcement Administration in Washington, said synthetic cocaine is rare and difficult to produce. The agency is unaware of the existence of any synthetic cocaine in the US.

Treatment limit is 3 years

(from page 1)

The particular Criminal Code amendments only come into effect in each province when agreement is reached with the province to proclaim the new provisions. It is expected that provinces will only agree to the proclamation after proper drug treatment facilities are available.

In introducing the new measures, Justice Minister Ron Basford said that, in the past, "emphasis has been given to a variety of measures designed to control narcotics trafficking.

"However, drug addicts often commit crimes in order to finance their habit.

"Thus, we feel it important to take constructive measures not only to punish criminals who are addicted to narcotics, but also to rehabilitate them.

"This not only benefits the offender but benefits society as a whole."

A federal lawyer involved in drafting the amendments told **The Journal** that the addiction treatment would normally not last any longer than two or three years.

One purpose of the proposed changes, he added, was to try to make it clear to courts that they shouldn't merely give an addict a fine for a drug habit-related crime and then allow him to go out and buy more drugs.

He said that the changes also allow courts to offer treatment to addicts in place of sending them to jail "to rot."

In both instances, the government is hoping judges will take the initiative and offer treatment to suspected drug addicts.

"It's designed to try and force everyone within the system to deal with addiction as a medical problem," the lawyer explained.

Meanwhile, other changes in the omnibus bill propose to take steps to cut pretrial delays: one measure would allow judges to make pretrial rulings before a jury is empanelled.

This, government officials say, should speed up major drug trafficking trials, by allowing the judge alone to decide on the admissibility of wiretap evidence and of confessions.

Other changes would provide a six month limit within a summary conviction trial by which time a trial must begin after an accused first appears in court. This should also help unclog courts filled with smaller drug cases. This section must also be approved by each province before implementation.

In another set of omnibus bill changes, penalties for drinking driver convictions have been standardized.

'Catch 22' blocks access to personal files

OTTAWA — The Human Rights Act provisions that give Canadians the right to check and challenge personal information kept in government data banks contain a curious Catch 22.

If the data bank in question is open and the government wants to exclude a particular part of your file, official notice of this has to be given if and when you request to see the file.

The effect is that you can not only find out whether a file exists in most cases, but also whether there might be something sensitive about you in that file.

And if you disagree with anything on the file, or question the reasons for information being excluded, you have the right to seek redress through the Privacy Commissioner in the Human Rights Commission.

And the Privacy Commissioner, an ombudsman of sorts, can request government agencies to justify refusals to provide information or to open a file, and can even take the government to the Federal Court, if necessary, all on behalf of an individual Canadian.

However, if the data bank or files in question are totally exempt from public scrutiny — as is the case with the 200,000 drug users' and distributors' files maintained by the federal bureau of dangerous drugs — then an individual Canadian suddenly faces trouble and a curious Catch 22.

Privacy Commissioner Inger Hansen admits that unless you can convince her the government is doing something wrong in denying you access to their exempt files, there's nothing she can do about the situation.

One Catch 22 is that you really have to know, at least in general terms, what is in the exempt file on you to make a convincing case. In fact, you have to have a pretty strong belief that a file even exists.

If you persist and put a convincing case before the Privacy Commissioner, she says she will attempt to find out whether a personal file exists, what is in it, and why the government won't let you see it.

If the government lets her see the files — something she doesn't have the power to force them to do — and she believes the department in question is not properly applying the Human Rights Act, then she can go to the Federal Court and try to get the Court to force a change.

If the department won't even let her see the files in question, then the commissioner has to decide whether a Court reference is worth the trouble and expense.

However, if all of this isn't confusing and frustrating enough, the Privacy Commissioner cannot, after all her inquiries, tell you what is in the exempt files or even that one exists — at least as long as cabinet agrees to keep them shut.

It's no wonder some legal experts within the health department argued that more of the department's files should have been totally closed to public review — that way no one could cause trouble even by asking to see their file.

Such a philosophy, if more broadly applied, could provide government bureaucrats with the ultimate weapon against overly-curious Canadians concerned that what the government has on them is correct; it also assumes that no one, or at least not very many Canadians, will attempt to question the exemption of total files from public scrutiny under the Human Rights Act.

Drug files treated the same as security data

(from page 1)

by neighbors, as well as information from police reports obtained for other purposes.

Under the blanket government exemption, none of this information can be checked by the affected individual, to ensure it is correct or to allow the individual to challenge inaccurate information and demand a change. These are essential rights available under the privacy provisions of the Human Rights Act for thousands of other federal files and data banks.

The effect is to put the drug user files into the same category as some two dozen highly-sensitive government data banks that have been exempted because they relate to national security matters or criminal investigations and because the very knowledge of their existence would threaten national security or criminal investigations.

Examples of these totally-exempted files are files on customs intelligence, on intelligence respecting threats to institutional security, and on security and intelligence information.

Government sources say that in almost all cases, cabinet had serious discussions and, in many cases, serious misgivings about granting blanket exemptions, even for files containing particularly sensitive information.

One reason is the fact the Human Rights Act gives government the power to exempt specific pieces of sensitive information in individual files, while making the rest of the information available to the named individual.

Grounds for exempting specific information on a case by case basis, and for exempting a total data bank, are essentially the same: for example, files that contain information that might be injurious to international relations, national defence or security, or federal-provincial relations, can be exempted specifically or generally.

Information gathered or prepared by investigative agencies relating to national security, crime detection or suppression, or in the course of investigations in connection with administration or enforcement of an Act of Parliament, can also be exempted specifically or generally.

How then did the drug user files get the same treatment as top-secret data banks on national security and on-going criminal investigations? — especially since the published two purposes of the drug files are to allow the government to prepare drug statistics for domestic and international use and to decide how to dispose of seized drugs, goods, and money?

The official answer to this question — and to the related question, which is why couldn't sensitive information be selectively kept from public scrutiny — was that there was so much sensitive information that the whole file had to be exempted.

However, unofficially, **The Journal** has learned that one major reason was pressure from the RCMP, which supplies much of the information used for one purpose in the file — that is, deciding how to dispose of goods seized in connection with drug charges — and which feared the consequences of any of this information getting out.

It turns out that one of the side effects of the Human Rights Act, and in particular the privacy provisions, is that government agencies can no longer give each other information on individuals from one data bank for use in another data bank, at least without notifying the involved individual.

Thus, in the drug cases, where large sums of money or drugs or other goods have been seized or found, the health department relies heavily on police reports of drug crimes in deciding who owns the property and what should be done with it. The police reports contain intelligence from informers and the like; they refer to persons who are known or suspected drug users or distributors who have never been convicted of a drug crime; and they contain clues as to how the drug squads collect information.

Even accepting the requirement for such information, major questions remain unanswered: how widely used is this sensitive information and how much of each drug file (most of them on cannabis users) consists of such information?

Mr McKim says he cannot say for sure, though he believes most files would contain some sensitive information that the named individual should not see.

Mr McKim also maintains the personal files are a necessity for statistical purposes, to ensure that individuals aren't counted more than once.

However, other officials in the health department who are aware of the nature of the drug files, disagree and admit names aren't required for statistics generation.

One such official added that those who have been convicted of drug offences can be sure the bureau of dangerous drugs has a file on them, even if they don't know what else is in it.

Those who have a reason for worrying, he suggested, are the ones who have never been convicted and who now cannot even find out whether a drug file on them exists.

California MDs support segregating smokers

SAN FRANCISCO — California's doctors have come out in favor of setting aside half of the area in public places for non-smokers.

At the 107th annual meeting of the California Medical Association, delegates threw their support behind the Clean Indoor Air Act of 1978, which would segregate smokers to designated areas in such public places as lobbies, waiting rooms, student and employee lounges, and railroad cars for non-smokers.

Every restaurant would have to establish a no-smoking section, but its size and location would be left to the discretion of the restaurant owner or manager.

Violation of the law would be punishable by a $50 fine. No one would be imprisoned for a violation of the law.

Proponents say the initiative would protect the health and environment of non-smokers who involuntarily inhale harmful tobacco fumes in enclosed public places and enclosed employment areas, according to a statement released by the sponsors which include the Clean Indoor Air Committee, the Group Against Smoking Pollution (GASP), and Californians for Clean Indoor Air.

Availability is key factor in drug abuse by US servicemen

(from page 1)

done for the committee.

It shows 85% of the officers think drug abuse hurts combat preparedness, discipline, and overall effectiveness of military personnel.

More than 90% think job performance is affected overall; 71% think drug abuse causes morale problems; 75% think half the lower ranks use marijuana at least weekly; and 77% think heroin is used at least monthly by a small group of personnel.

Mr Dogoloff, who presented the White House position to the committee, told The Journal: "We have two major concerns.

"One is that with the Congressional mandate that we discontinue random urinalysis, it is awfully tough to know the true nature and extent of drug use. We have asked for that to be resumed.

"Our second is that drug abuse is more than anything else probably a function of availability. When our troops are in areas of high availability, for example West Germany, then they are obviously as vulnerable as are the civilian population.

"What we want to do is increase the number of unit urinalysis sweeps, specifically in areas where we know there is high availability.

Commanding officers can have a suspected individual tested, or order a command test where urine is given by all personnel.

Mr Dogoloff said that during his February European visit at his request he talked alone to two separate groups of enlisted personnel. "They told me they felt comfortable with the idea of random testing when a serial number comes up."

Random urinalysis is not the final answer "but it is obviously one of the things that without it, it is difficult to have any accurate survey data."

Mr Dogoloff added: "We think random urinalysis in, and of, itself is one of the better prevention techniques we have. The likelihood of being detected is a tremendous molder of behavior."

Among the personnel who handle nuclear weapons, figures for 1976 show 1,474 were transferred for drug abuse, and 184 for alcohol abuse.

Mr Dogoloff said: "The nuclear program has very high standards, and it would be very difficult for someone who is either prone to, or involved with, drugs to get into and remain in it."

Mr Dogoloff, in his testimony to the committee, said it is not known exactly what the overall picture of drug use is.

"In terms of existing indicators — that is medical reports, law enforcement reports, and so forth — it appears that overall drug use within all three services is down from the epidemic proportions experienced during the Vietnam era.

"But we are not confident we know the trends of drug use or can identify quickly shifting patterns of drug use."

He gave a thumbnail picture of members of the forces: many of the enlisted men and women have joined because they can't find a civilian job, often they don't have a high school education and they are given complex training.

"Add to this the high availability of drugs in parts of Western Europe, the age of most servicemen and women, and the changing mores regarding drug use in our society, and it becomes clear that we are not going to avoid the problem of drug use.

"The question is, how can we minimize it?"

Street prices jump for prescription drugs

SAN FRANCISCO — When several of California's drug-pushing doctors were arrested in April, street prices of commonly abused prescription drugs more than doubled throughout the state.

With more arrests coming up the prices could go higher.

New legislation will soon make it a federal offence for a pharmacist to fill a prescription in the absence of satisfactory medical reasons.

And several commonly misused drugs, such as Valium, Librium, Darvon, and amphetamines will be put on the list of "controlled substances."

All of these recent developments are the result of Operation DOPE, a newly initiated consumer affairs program aimed at cracking down on doctors and pharmacists who provide unnecessary prescription "uppers" and "downers" to drug users.

(The acronym stands for Doctors Out Pushing Ejected.)

"These doctors have prostituted their drug-prescribing privileges to pursue not health, but rather their own financial greed," according to Department of Consumer Affairs Director Richard B. Spohn.

"One doctor wrote for one client in a two-month period prescriptions for 1,500 Quaalude tablets, 4,000 amphetamine tablets, 2,500 Seconal tablets, and 2,700 Percodan tablets," Mr Spohn said.

So far, eight doctors have been arrested and will soon lose their licences.

In addition, licence revocations have been filed against eight more doctors who have been writing "scrip," and seven pharmacies who have been working in collusion with them.

The department suspects there are about 300 doctors and 200 pharmacists involved in illicit drug distribution statewide, Mr Spohn said.

Operation DOPE is composed of investigators from the Board of Medical Quality Assurance, agents from the state Pharmacy Board, and lawyers from the Attorney General's Office.

The formation of Operation DOPE followed a series of articles in the *Los Angeles Times* charging that a small number of physicians write prescriptions for more than 90% of the pills sold on the black market.

Key to the success of the operation is a newly passed law in California that permits the Board of Medical Quality Assurance (BMQA) to step in and get a restraining order against a doctor from practising when it might endanger the safety, health, or welfare of the public.

BMQA President Florence Stroud, RN, predicted that the strike force would mop up about 80% of the "excessive prescribers" in California.

The BMQA, which is the state licensing board, currently has 231 drug-related cases under investigation.

Accusations have been filed in 68 of these cases.

"We're going to get everybody we can," she told **The Journal.** "We're definitely going after more.

"We're working with the Board of Pharmacy to go after pharmacists that often work in collusion with 'scrip' doctors."

The California Medical Association and California Pharmaceutical Association have strongly supported Operation DOPE, according to Mr Spohn.

"Indeed, the pharmacy association has asked its members to send to it, for forwarding to operation DOPE, names of doctors they suspect of pushing drugs."

Cigarette smoking found associated with cervical cancer

By Jean McCann

HOUSTON — Cigarette smoking has a new strike against it. It's now been associated with cancer of the cervix.

How and why is not known, Warren Winkelstein, Jr, dean of the school of public health at the University of California at Berkeley, told a seminar for science writers sponsored by the American Cancer Society.

Yet a Swedish epidemiologic study clearly points up an association, he said. It indicates a rate of cervical cancer of 20.2 per thousand in smoking women, compared to only 4.0 in non-smoking women who never took up the habit.

Furthermore, the Third National Cancer Survey in the United States shows cervical cancer occuring in isolation, and not with the cluster of other female cancers (those of breast, uterus, and ovary).

Dr Winkelstein said cigarette smoking is one of the few definitely-proved environmental causes of cancer.

He said if men would quit smoking, the incidence of cancer of the five most common kinds in men (cancer of the lung, prostate, colon, bladder, and stomach) could be reduced by 35%.

Lung cancer in men has the highest mortality rate, and has a proved relationship with cigarette smoking. In women, it is now fifth in incidence with the second highest mortality rate, but Dr Winkelstein said he expected it to be in the number one position in the female sex by 1986, as it is with men now.

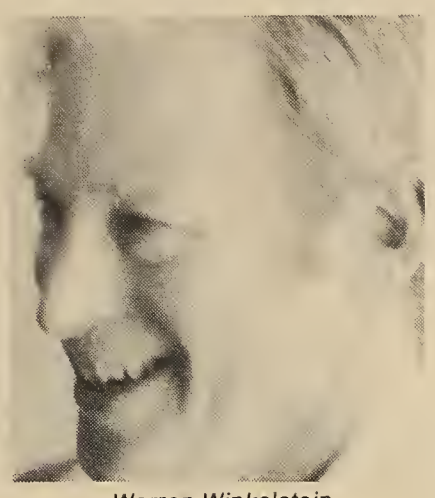
Bladder cancer, another malignancy causally associated with cigarette smoking is on the increase also. With elimination of smoking, this disease could be reduced by about 40%, Dr Winkelstein said.

If women quit smoking, this "can be predicted to result eventually in an approximate 70% reduction in lung cancer, for an overall reduction of 7% in incidence of the five most frequent female cancers (those of the breast, colon, corpus uterus, cervix uterus, and lung)."

"In my opinion, no discussion of the broad issues of cancer and the environment should fail to begin with a consideration of the impact of cigarette smoking. This factor is the best-established, most commonly encountered environmental carcinogenic agent. It should be given primary consideration in the establishment of cancer prevention policies.

Arthur C. Upton, director, National Cancer Institute, spoke of the synergistic effect of cigarettes and other carcinogens.

"There is evidence of dose-dependent carcinogenesis for certain chemicals and tobacco.



Warren Winkelstein

For example, the risk of lung cancer appears to increase in proportion to the number of cigarettes smoked per day, and the dose-effect curves do not provide any evidence of a threshold.

"It also appears that the combined effects of carcinogens may sometimes be multiplicative, rather than additive, so that the total effect of a combination of agents may greatly exceed that to be expected on the basis of studies with agents singly."

Paraquat scare sparks new push to legalize home grown marijuana

SACRAMENTO, CA — Proponents of "grow your own" marijuana are saying the paraquat controversy could give the movement the boost it needs to regain momentum.

West Coast director of the National Organization for Reform of Marijuana Laws (NORML) Gordon Brownell says the dangers of paraquat have to make lawmakers more receptive to self-cultivation bills.

"The only way a person can be sure his or her marijuana hasn't been poisoned by United States' tax dollars is to grow their own," he says.

"If people are going to smoke the stuff anyway, one of our responsibilities is to protect their health.

"And the best way to do that is let them grow it at home," according to Assemblyman Willie Brown (Dem-SF).

Recently, almost one-third of the members of California's State Legislature signed a letter calling on President Carter to halt US support of the paraquat spraying program.

Mr Brownell said also he found it "significant" that Governor Brown is chilly to the paraquat spraying program.

The governor was quoted recently as calling it "dumb".

Assemblyman Tom Bates (Dem-Oakland), who sponsored the letter, cautioned that marijuana laws are a separate issue from paraquat.

"Our letter dealt only with a health issue," he said.

'It's targeted at children'

Califano calls cigarette advertising sinister

By Harvey McConnell

WASHINGTON — A roundhouse punch has been delivered to the American tobacco industry by Joseph Califano, secretary of health, education and welfare, for advertising he claims is aimed at children.

Mr Califano said much of the advertising is "sinister."

He added: "All you have to do is look at the handsome Marlboro man, look at the glamorous women. You'll see it's targeted at the children."

Such advertising entices, each day, 4,000 children and teenagers to start smoking, Mr Califano said.

Some 75% of smokers take up the habit before they reach age 21, and it's estimated 100,000 children 13 or younger smoke a pack of cigarettes each day.

"This is not a decision made by adults 30- to 35-years old who are aware of all the health problems. The tobacco industry has mounted a very sinister campaign designed to encourage teenagers to smoke," Mr Califano said.

He said the $30 million anti-smoking campaign he launched recently is paltry compared with the $174 million spent by the government on anti-alcohol programs, and $275 million to fight drug abuse.

Yet neither alcohol nor drug abuse costs anything remotely near what smoking costs.

Most of the money for the anti-smoking campaign will go for research. A major study will be made into why children start smoking.

As part of his anti-smoking drive, Mr Califano has appointed John Pinney, formerly with the National Council on Alcoholism here, to head the new office of Smoking and Health.

Mr Califano made his remarks to a meeting of the American Society of Newspaper Editors.

Tough anti-smoking law proposed for DC

WASHINGTON — A draconian anti-smoking law, which would make it tough to puff a cigarette almost anywhere in public in Washington, has been proposed by a committee of the District of Columbia city council.

The proposal came in for sharp editorial criticism by *The Washington Post* and *The Washington Star*, and is worrying the tourist and restaurant business.

Under the proposed law, smoking would be prohibited in all but segregated rooms in public as well as private offices, businesses, and industrial concerns, and in public galleries, meeting rooms, convention halls, and public areas in hospitals and clinics.

The model used was the state law of Minnesota, the toughest in the United States.

Restaurants with 50 seats or fewer would not be affected, but segregated areas would have to be provided in large restaurants. Managers would be forbidden to serve food or drink to anyone smoking a cigarette in a banned area.

The move to try to stop smoking in private offices and industries has aroused so much comment that the committee has decided to "define more explictly" what is meant before it is submitted to a full council vote.

The Washington Star, in a scathing editorial, said the only element lacking in the bill "is a prohibition on the noxious weed in private homes and apartments."

It said the present anti-smoking zeal in the country "is a brilliant example of authoritarian rectitude — a manacling of the individual for his own good.

"We are not really talking about smoking, in this instance, so much as the imposition of social control — a control that, once established, can extend itself wonderfully to areas of human activity that do not accord with the values or views of those in power."

The Star editorial objected to the idea of trying to ban smoking in private business. "It is no duty, responsibility, or prerogative of local government to order private entities to conform to its notion of what is correct social demeanor where basic principles of equity are not involved."

The Washington Post said committee members went one step too far by trying to ban smoking in areas serving as a place of work.

"That means just about *anywhere* people work — which is pretty much everywhere — would be subject to the ban on no smoking . . . ."

Prohibition of smoking in certain areas is not objectionable, the *Post* editorial added. It called for the bill's rejection because "a ban on smoking in work areas just can't be enforced."

The committee heard some 90 witnesses in two years of hearings. Most opposition came from representatives of the restaurant, tourist, and convention businesses who claimed such a ban would drive away trade.

A first offender would be fined $10, and a repeat offender up to $100 and 10 days in jail under the proposal.

Undercover drug agents cause tension in schools

FAIRFAX, VA — A student circulated petition claims "an atmosphere of tension and potential violence" has existed in Fairfax County high schools since officials announced they have used undercover narcotic agents.

Officials said the agents were withdrawn from the schools before the announcement was made. It was the first time since the 1960s agents had infiltrated some of the 22 schools in the county.

The aim was to gain information on drug trafficking mainly in alcohol, marijuana, and PCP, on school property. No arrests were made.

Students claim most of them are now suspicious of any new student, and this creates tension. Police Chief Richard King said the reason the program had been announced "was because we didn't want to trap students."

EDITOR
Anne MacLennan

STAFF WRITER/PRODUCTION EDITOR
Karin Pargas

CONTRIBUTING EDITORS
Harvey McConnell (Washington)
John Shaughnessy (Toronto)

SCIENCE EDITOR
Dr Ruth Segal

The Journal

Published by Addiction Research Foundation of Ontario
33 Russell St, Toronto, (416) 595-6053

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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Letters to the Editor

Stress polydrug use

I enjoy **The Journal** very much, and feel the articles are always informative and current.

However, as a state surveyor for the health department (health, education, and welfare regulations — Medicare and Medicaid) I would be interested in seeing information on regulations or articles concerning the use of prescription drugs as related to illicit trade.

Although alcohol, cocaine, and heroin are the largest headline grabbers, I don't feel enough attention is given to polydrug use. Such drugs could include Valium, Quaalude, amphetamines, barbiturates, Talwin, etc (primarily central nervous system stimulants and depressants.)

Keep up the good work.

Henry T. Kozek
Glassboro, New Jersey

Second-hand smoke

The Factsheet on tobacco, (**The Journal**, November) seems to me to contain some misleading information. Under Non-Smokers' Rights it states: "There is no evidence that a tobacco-smoke filled environment is bad for the health of healthy non-smokers, except possibly children."

Yet according to a number of studies, the sidestream smoke (smoke from the burning end of a cigarette) has higher concentrations of noxious compounds than mainstream smoke inhaled by the smoker. Among these are tar, nicotine, cadmium, ammonia, benzene, formaldehyde, nitrogen dioxide and carbon monoxide. Many of them are carcinogens, one of them (cadmium) is suspected of causing emphysema, and the carbon monoxide level of air in a room with smokers present can easily reach hazardous levels (carbon monoxide robs the blood of oxygen by combining with hemoglobin.)

This information is contained in the leaflet called *Second Hand Smoke* published by the Lung Association, according to which there are literally hundreds of chemical compounds in tobacco, and hundreds more created when tobacco burns, a large number of which are hazardous to health. For example, one of them, hydrogen cyanide, is a poison that attacks respiratory enzymes. The concentration in cigarette smoke is 1600 ppm; long term exposure to levels about 10 ppm is considered dangerous. Nitrogen dioxide is an acutely irritating gas that can damage the lungs. Levels of 5 ppm are considered dangerous; cigarette smoke contains 250 ppm.

It is hard to see how inhaling carcinogens and other noxious substances can fail to be bad for even the healthiest non-smoker. While I appreciate that the Addiction Research Foundation may not wish to be drawn into controversy regarding the effects of second-hand smoke, it seems surprising that it would seek to minimize rather than to emphasize the potentially hazardous effects of smoking on the innocent bystander.

Brenda Gibson
St Catherines, Ontario

The best there is

I enjoy **The Journal** and look forward to it. I use the information regularly.

Since my exclusive interest and use is in alcohol problems, I sometimes think it is too heavy on other drugs. But **The Journal** is the best I know of.

Keep up the good work.

Harry Beardsley
Public Relations
Preferred Risk Insurance Company
Des Moines, Iowa

He missed the news

I love it. I love the photo of Arthur Young, executive director of the alcoholism program of the New Brunswick department of health, smoking that great big pipe, with the smoke wreathed around his head. (**The Journal**, April). And to think that right in **The Journal** we read that tobacco addiction is one of the biggest drug addiction problems — yes, bigger, according to some of your experts, than alcohol addiction.

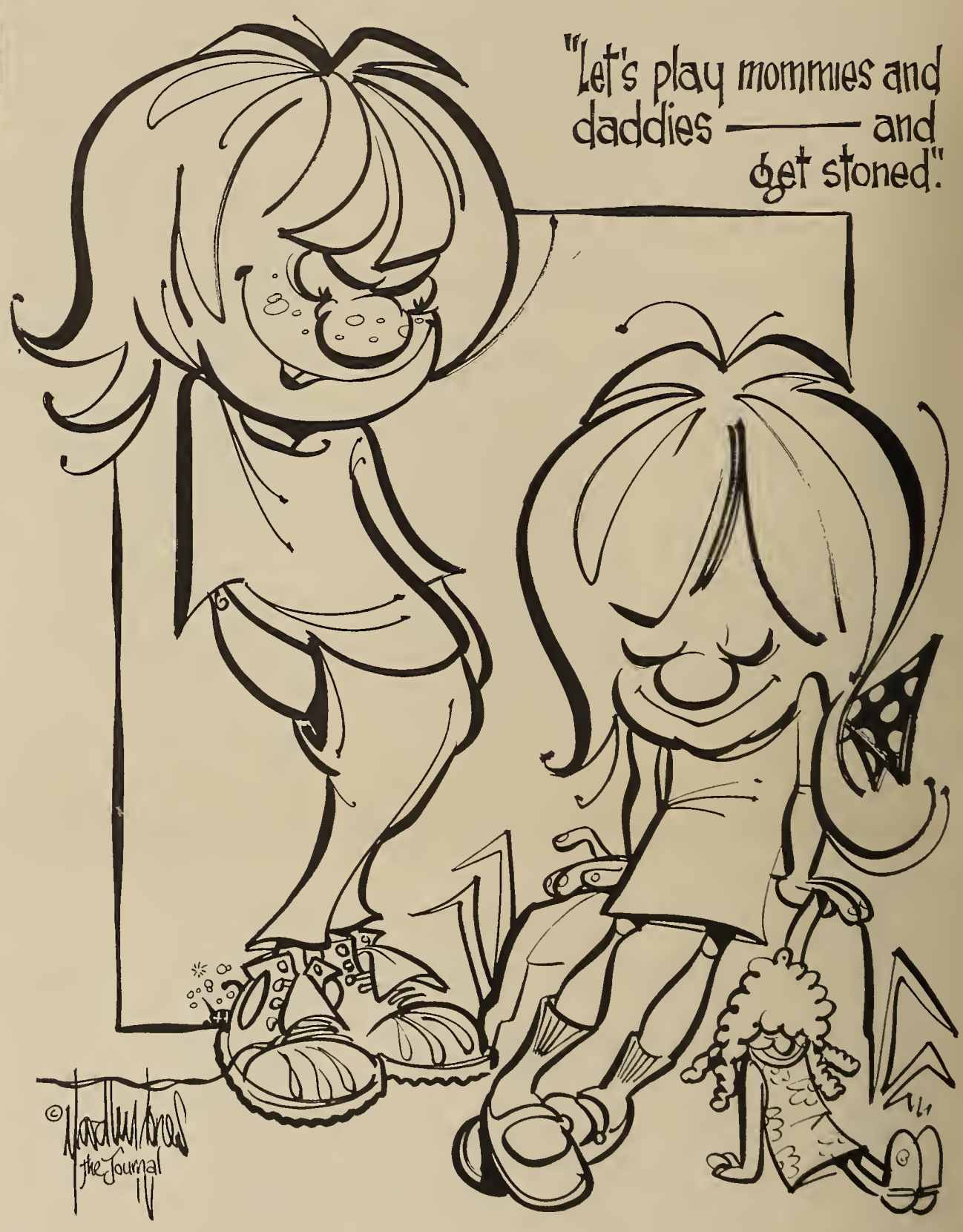
On page 13 of the April issue, there's an article headed World war on smoking set, calling smoking "one of the greatest challenges to preventive medicine of our time." Guess they didn't get the news over at the NB department of health.

I'm adding this picture to my Great Ironies of Life file.

Barbara Ford
Mendham, New Jersey



Arthur Young



Alcohol programs fail in the UK

The British mental health establishment is being made aware of its own near total failure to diagnose or treat the disease of alcoholism.

The Lancet, the most renowned medical journal in Great Britain, published a study of Alcoholics Anonymous in its Feb 18, 1978 issue. The survey of AA was funded by David Ennal's DHSS (department of health and social services) and carried out with the help of 50 British AA groups during 1976/77 by Drs Stuart Henry and David Robinson at the Addiction Research Unit at the Institute of Psychiatry.

It is a pity the research team at the Institute of Psychiatry has not always been involved in such valuable research into the alcoholism field. A monumental amount of public money has been poured into alcoholism research over the past two decades but it is near impossible to discover when, if ever, much of this costly effort will be evaluated and made available to the public.

As All Faiths' World Alcohol Projects (ALFAWAP) is now the self-appointed watchdog in the UK field of alcoholism, we hope to see great changes for a better working relationship among the numerous bodies in the field here, all shouting for more money.

Congratulations on your report of readers' interest in AA. (**The Journal**, Feb). Congratulations also to all of your readers who took the time to put Patricia Armstrong back "on the beam."

The Rev Ronald Forbes
Managing Editor
ALFAWAP Journal
London, England

AA is just one way

I read with interest Pat Armstrong's letters to the editor (**The Journal**, November, April). I too, have a history of alcoholism and drug addiction, and found myself at the doors of Alcoholics Anonymous over two years ago.

I want to say that Ms Armstrong's letter reinforced and reaffirmed my own decision to move away from AA and Narcotics Anonymous.

I felt with spending two years in the program I had internalized the 12 steps — steps that still permeate my daily life. I started feeling that dwelling in the past constantly was not for me — especially when I'm attempting to build a good, solid present for myself.

I am not recommending that people should leave AA/NA and try to do it on their own. My decision was my own, made very carefully, and with some trepidation.

My feeling is that for some people, AA/NA is a stepping stone towards more growth-oriented activities. However, I do not want to diminish the importance of the early stages of my recovery in those programs. Both programs gave me my first ray of hope for recovery. I have found that AA/NA is not the only way.

Millicent Buxton
Information Coordinator
Haight-Ashbury Free Medical Clinic
San Francisco

Special Supplement to

The Journal

June 1, 1978

A Strategy

for the Prevention of

Alcohol Problems

Addiction Research Foundation

Background Information and Recommendations for the Parliamentary Debate on Control Measures

from the Executive Committee of the Addiction Research Foundation of Ontario, February 17, 1978

A STRATEGY FOR THE PREVENTION OF ALCOHOL PROBLEMS: BACKGROUND INFORMATION AND RECOMMENDATIONS FOR THE PARLIAMENTARY DEBATE ON CONTROL MEASURES

From the Executive Committee of the
Addiction Research Foundation of Ontario
February 17, 1978

It is understood that the legal drinking age and related policy issues are shortly to be debated. To facilitate this debate, background information on the problems of alcohol is provided, together with an assessment of the role of control measures in the prevention of such problems and a recommended preventive strategy.

NATURE AND MAGNITUDE OF ALCOHOL PROBLEMS

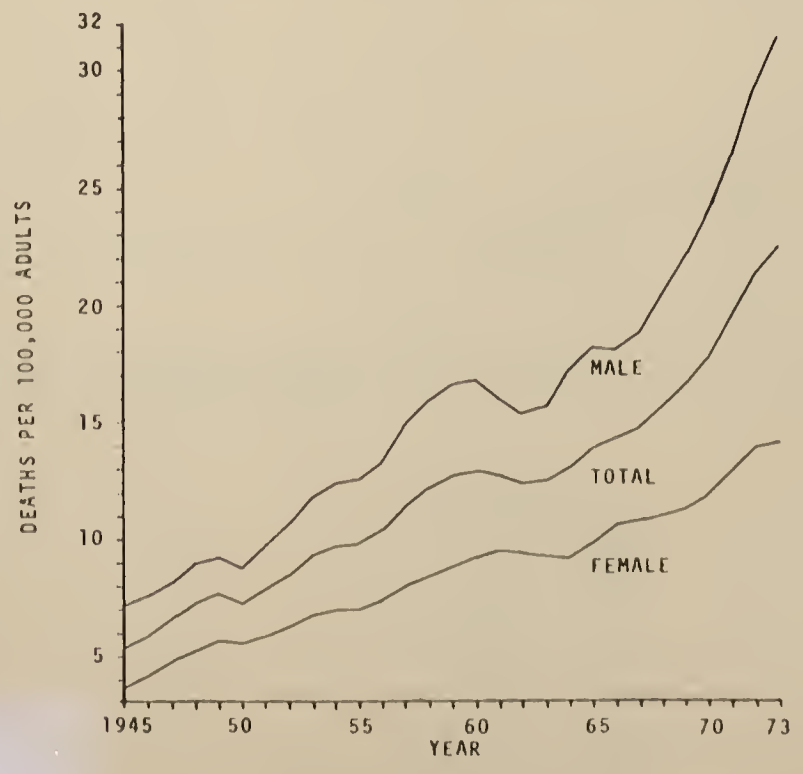
At the outset, it is important to stress that all alcohol-related problems are not attributable to alcoholism or chronic drunkenness. The risk of physical disease resulting from alcohol use is now known to increase significantly at levels of consumption much below those ordinarily associated with the alcoholic. Most alcoholics seen in clinics drink in excess of 15 centilitres of absolute alcohol per day (the equivalent of about 12 oz. of distilled spirits or 8 bottles of beer). However, an intake of less than half as much, consumed regularly over long periods, measurably increases the risk of cirrhosis and certain cancers. Alcoholics, in fact, are only a minority among the drinkers who consume quantities that are liable to produce illness and premature death.

With respect to overall magnitude, it has been said that in many countries only cancer and cardiovascular ailments exceed alcohol-related health problems in number of victims, the misery caused the sufferer and those close to him, or in the economic cost of these conditions to the community as a whole. While it is difficult to fully substantiate such a comparison, the relevant point is conveyed: the problem is a very serious one and, in this respect, Ontario is no exception. However, this point has been made many times in recent years and need not be further elaborated (see reference list). It is of greater immediate relevance to consider the data bearing on future trends.

There is no better indication of the trend in the prevalence of alcohol-related health problems than changes in the rate of death from cirrhosis of the liver. This disease is common among heavy drinkers and the importance of prolonged heavy intake of alcohol as a cause of the disease has been established beyond doubt. Since the amount of drinking which leads to cirrhosis also leads to many other problems, trends in the rate of death from this disease reflect trends in chronic alcohol problems generally. As shown in Graph 1, the death rate from cirrhosis in Ontario has been increasing rapidly throughout the post-World War II period.

GRAPH 1

LIVER CIRRHOSIS DEATH RATES IN ONTARIO, 1945-1973



Indeed, it has been the most rapidly increasing cause of death in the adult population followed by lung cancer and suicide (Table 1).

TABLE 1

DEATHS PER 100,000 ADULTS AND AVERAGE ANNUAL PERCENTAGE CHANGE IN DEATH RATES FROM CIRRHOSIS, LUNG CANCER AND SUICIDE ONTARIO. 1950-1973

Cause of Death	Rate of Death 1950	Rate of Death 1973	Rate of Change in % Male	Rate of Change in % Female	Rate of Change in % Total
Cirrhosis	7.7	22.6	10.48	6.39	8.80
Cancer of Lung	19.2	52.7	7.64	10.78	7.95
Suicide	13.7	20.0	1.29	4.96	2.10

It is also noteworthy that the increase has been greatest among persons 35 to 49 years of age (Table 2). This is particularly important when the impact of the disease is judged in terms of loss of productive years of life.

TABLE 2

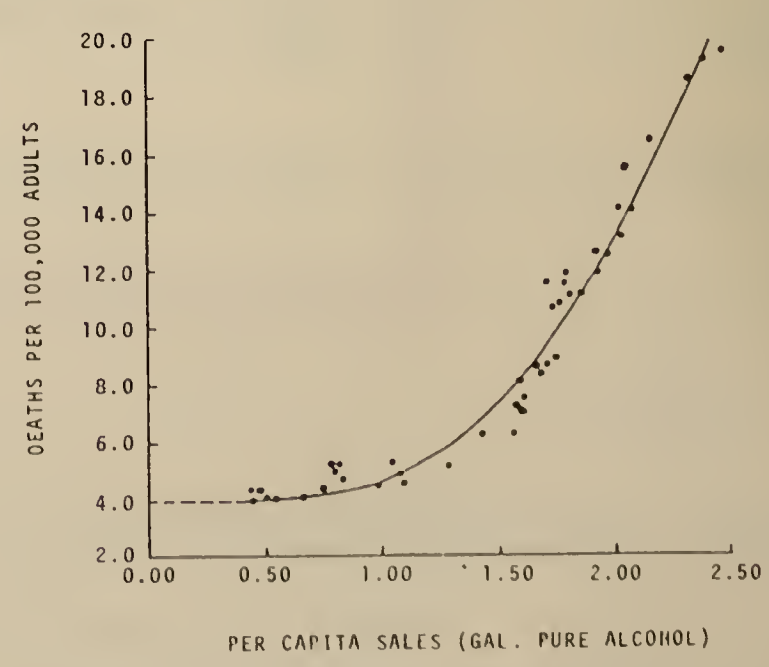
AVERAGE ANNUAL PERCENTAGE CHANGE IN CIRRHOSIS DEATH RATES BY AGE AND SEX IN ONTARIO, 1950-1973

Age	Male %	Female %	Total %
20 - 34	8.46	2.04	4.76
35 - 49	14.10	9.44	12.40
50 - 64	10.10	5.27	8.04
65+	5.64	2.64	4.05

Graph 2 illustrates the close relationship between the cirrhosis death rate and per capita alcohol sales. This reflects the now well-established principle that the overall level of consumption is directly related to the magnitude of alcohol problems: the larger the amount of alcohol consumed by a population as a whole, the larger the number of heavy consumers and the greater the damage to public health.

GRAPH 2

THE RELATIONSHIP BETWEEN PER CAPITA ALCOHOL SALES AND LIVER CIRRHOSIS DEATH RATES IN ONTARIO DURING THE PAST 44 YEARS

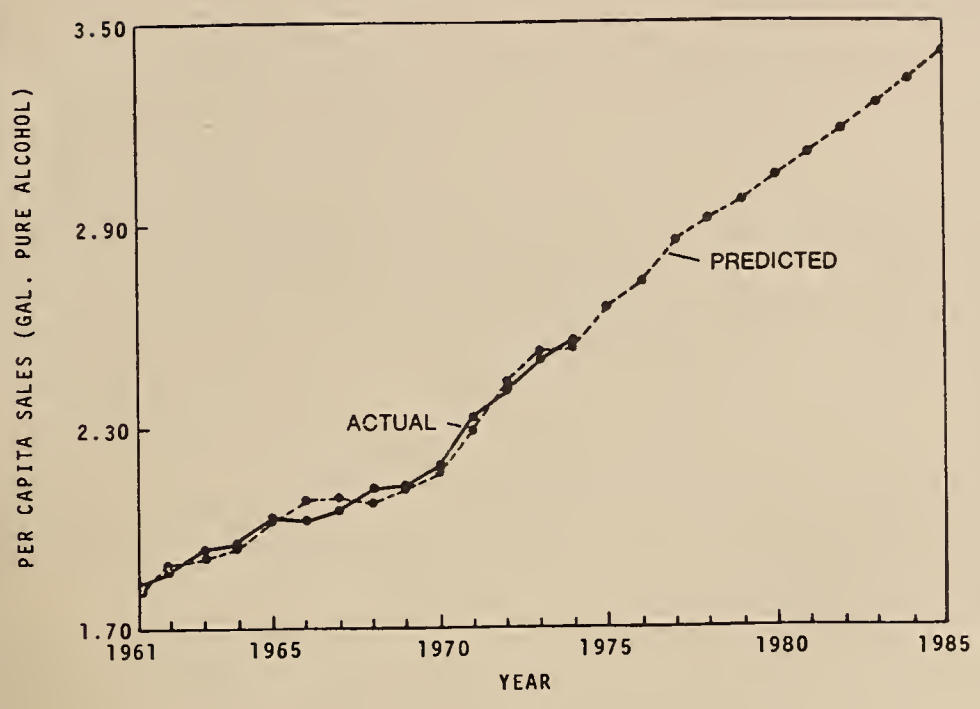


Thus, from a standpoint of preventive strategies, it is crucial to consider what the future may hold in regard to trends in the sale of alcoholic beverages. A forecast based on past trends and the best available indicators of future economic conditions is provided in Graph 3.

The expectation is that the present rate of increase will continue and that, by 1985, per capita sales in Ontario will be about 50% greater than in 1975. The relationship between sales and the prevalence of alcohol-related problems is such that an even larger increase would be expected in the latter.

GRAPH 3

PREDICTED AND ACTUAL ONTARIO SALES OF ALCOHOLIC BEVERAGES



LEGAL CONTROL MEASURES

Clearly, the crucial issue becomes the development of a strategy to prevent the expected increases in alcohol sales. There is little doubt that an appropriate legal control system is essential to the effectiveness of such a strategy. Accordingly, it is important to review the available information respecting the impact of the principal control measures currently employed.

Age Limits

Biennial surveys of the school population, conducted since 1968, have shown a steady increase in the proportion of users of alcohol. And evidence has been accumulating of a decline in the age of clinical admission for treatment of serious alcohol problems. These trends predate the lowering of the drinking age in 1971, and presumably reflect the trends already described for the adult population. Nevertheless, careful research has shown that the change in drinking age significantly increased the level of both per capita consumption and the incidence of alcohol-related traffic accidents in the age group affected (18 to 21 years). Similar results have been reported for several other jurisdictions in which the age limit was lowered; and in a recent follow-up study from the State of Michigan it was shown that the impact on alcohol-related accidents was not a temporary reaction but had persisted over several years.

It does not follow from these findings that raising the drinking age would entirely undo the effects of lowering it. At present there is no direct evidence bearing one way or the other on this point. Raising the drinking age might serve to increase the number of violators of the age law. Nevertheless, it is probable that there would be some reduction in consumption and attendant problems. In addition, such a step would represent an expression of government concern, having educational value in its own right, and would serve to facilitate control of alcohol-related disciplinary problems in secondary schools. On balance, therefore, an increase in the legal drinking age should be beneficial.

In any case, it is well to remember that young people imitate the drinking models of the adult world. Accordingly, the ultimate issue remains that of a strategy of prevention applying to all, and aiming to alter the trends in the drinking population as a whole.

Licensing Regulations

Over the past 30 years, changes in licensing regulations in Ontario have all been in the direction of liberalization. For example, the sale of distilled liquors by the glass has been permitted, hours of sale have been extended, sale on Sundays introduced, and licenses have been issued to premises in a steady increasing number of new settings—for example, trains, aircraft, museums, art galleries, office buildings, and university campuses. So far, it has not been possible to demonstrate specific adverse effects attributable to any one of these changes taken separately. Nevertheless, the cumulative effect has represented a major alteration in availability and, therefore, has undoubtedly contributed to the increases in consumption and attendant problems over the period.

Another important consideration with respect to changes in licensing regulations is the message thereby conveyed. The public has long accepted a governmental role in health protection and relevant legal constraints as a consequence. Accordingly, a relaxation of controls in the alcohol area must inevitably convey the view that alcohol consumption is considered to be harmless or less harmful than once thought. This message is reinforced when 'life-style' advertising of alcoholic beverages is permitted.

Advertising

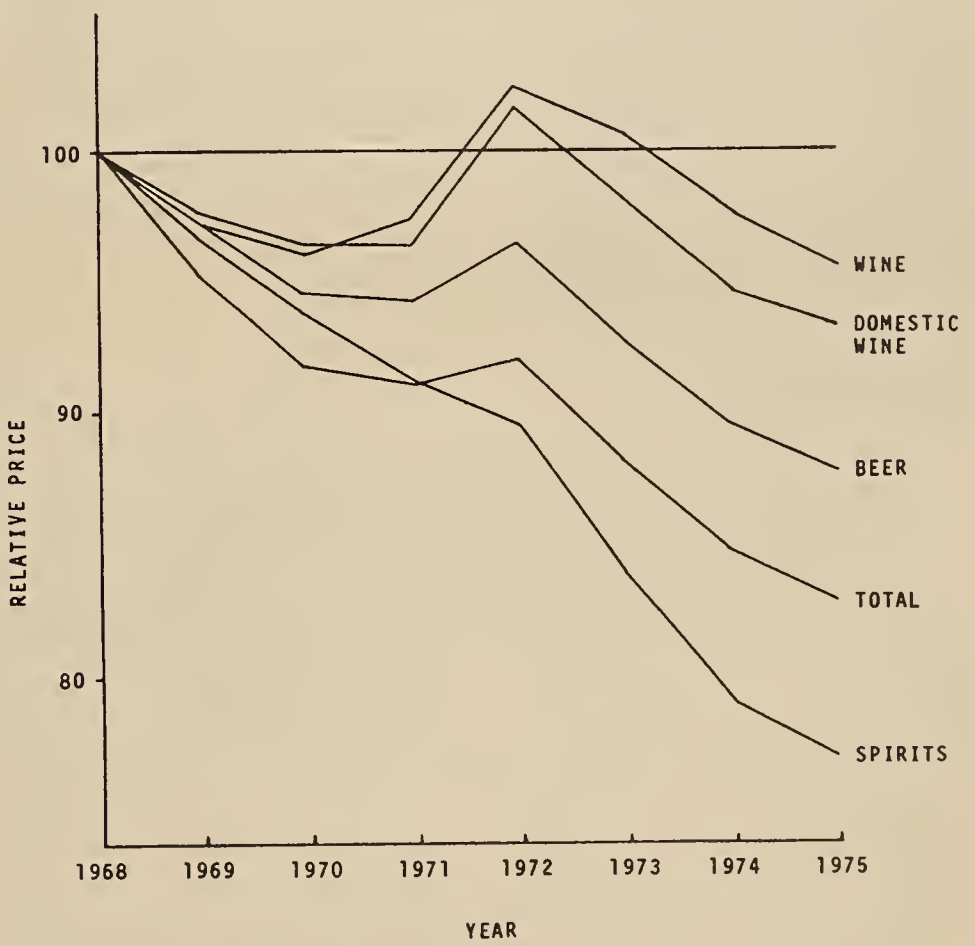
The impact of alcoholic beverage advertising on overall consumption is as yet poorly understood and, indeed, the problems of research on this topic are formidable if not insurmountable. For example, it is difficult to imagine how one could assess the impact on adult drinking of an exposure to advertisements which may begin in childhood. Nevertheless, it is reasonable to postulate that advertising which portrays alcohol use as a natural and desirable part of everyday life increases acceptance of drinking and hence, potentially, the level of consumption in the population.

Taxation

From an economic standpoint, alcoholic beverages behave as other commodities on the market: a drop in real price generally leads to an increase in consumption. This is pertinent in light of the decline in the cost of beverage alcohol relative to other consumer goods in Ontario. While the trend is characteristic of the entire post-World War II period, it has been particularly marked in recent years as shown in Graph 4.

GRAPH 4

PRICES OF ALCOHOLIC BEVERAGES RELATIVE TO THE CONSUMER PRICE INDEX LEVEL, ONTARIO, 1968-1975 (1968 = 100)



The decline in cost is due to the fact that the prices of alcoholic beverages are to a large extent determined by taxation (excise duties and mark-ups) and are, therefore, relatively insensitive to inflationary pressures. Only a deliberate adjustment of the tax level from year to year could prevent significant decreases in real price during periods of inflation.

CONCLUSIONS

The conclusions which appear to be directly relevant to any debate on control issues are as follows:

1) The overall consumption of alcoholic beverages in a population is an important determinant of the magnitude of alcohol problems. Hence, any control measure which affects the volume of sales of alcoholic beverages may be expected to affect the prevalence of these problems.

2) The rates of alcohol sales and attendant health problems have risen steadily during the post-World War II period in Ontario and, in the absence of appropriate preventive action, current indications are that this trend will continue.

3) The post-World War II period has been characterized by a

gradual relaxation of restrictions on the availability of alcohol, a lowering of the legal drinking age, the rise of extensive life-style advertising of alcoholic beverages, and a decline in the real price of alcohol. These changes appear to have contributed significantly to the increase in consumption over the period.

RECOMMENDATIONS

In an overall preventive strategy, the legislative approach must be complementary to educational and treatment approaches. It would be entirely unrealistic—and might well have considerable adverse consequenses—to attempt to control the problem entirely by means of taxation and highly restrictive control measures. On the other hand, it has become evident that education and treatment alone can have little impact when liberalization of the control system including lowering the drinking age, extensive alcoholic beverage advertising, and declining real prices constitute forces operating in the opposite direction. Under these circumstances, it is clear that an integrated approach is required. The following recommendations are consistent with this point of view.

1) *There should be not further liberalization of alcohol control measures and a health-oriented policy with respect to such measures should be adopted.* Essentially, this would mean that future proposals to change legislative or other provisions governing the marketing and distribution of alcoholic beverages would be tested against a health objective: the prevention of further increases in the prevalence of alcohol problems. The relevant question would become: are the proposed changes likely to contribute to higher consumption levels and therefore to an increase in health costs?

2) *A pricing policy should be adopted by the Government of Ontario such that a reasonably constant relationship is maintained between the price of alcohol and the consumer price index.* In addition, the price structure should be adjusted so as to minimize discrepancies in the cost of alcohol obtained through the least expensive beverage in each class: beer, wine, and spirits. This would prevent increases in alcohol, consumption through a shift to cheaper sources of beverage alcohol; for example, from distilled spirits to beer.

3) *The legal drinking age should be increased.*

4) *Life-style advertising of alcoholic beverages should be discouraged.*

5) *There should be a vigorous effort to increase public awareness of the personal hazards of heavy alcohol consumption, the economic and other consequences for society of high consumption levels, and the potential public health benefits of appropriate control measures.* Many approaches are needed to achieve this objective but there are three which deserve special note in the present context.

i) The mass media alcohol education program conducted by the Ministry of Health in 1975-76 should be continued and strengthened. A preliminary evaluation of the impact of the program indicates that it had some success in reaching and being understood by its audience. It is unrealistic to expect a significant effect on drinking behavior on a short term basis, especially in the absence of a complementary legal control policy.

ii) The Addiction Research Foundation, through its community development program, will seek to influence private industries and such large institutions in the Province as labor unions, service clubs, military establishments, and universities, to adopt a health-oriented policy with respect to alcohol use. To date, the concern has been mainly to generate interest in assistance programs for those already displaying problems as a consequence of drinking. However, an attempt should be made to encourage large organizations to formulate a more comprehensive policy aiming also at prevention. This may help to forestall current trends towards increasing the availability of alcohol within the jurisdiction of such organizations.

iii) A message indicating the principal long term health hazards of alcohol use should be distributed through the retail outlets of the Liquor Control Board of Ontario. The message should be under the imprimatur of the Ministry of Health and be routinely packaged with every purchase. The content envisaged is indicated by the attached draft: Some Information about Drinking and Health.

PROPOSED MESSAGE FOR DISTRIBUTION TO CUSTOMERS OF LCBO STORES

SOME INFORMATION ABOUT DRINKING AND HEALTH

The risk of serious disease increases with the amount of alcohol consumed. For example, drinkers who consume the amount of alcohol in 20 to 30 bottles of beer or 30 to 45 oz. of whisky each week over a number of years have a greater likelihood of developing cirrhosis of the liver or certain types of cancer. The danger to health increases rapidly when larger amounts are consumed. In the case of the cancers, the risk is even greater when drinking is combined with smoking.

To assess the risk associated with your present level of drinking, fill in the table below:

How many of each of the following do you drink per week?

(The amount of alcohol contained in each of the quantities listed is about the same.)

	No. of Each
12 oz. bottles of beer	_____
1½ oz. drinks of liquor (whisky, gin, rum, liquers, etc)	_____
3 oz. drinks of sherry or port	_____
5 oz. drinks of table wine	_____
TOTAL	_____

If your total exceeds 20, you are drinking an amount which may be hazardous to your health. It is important to realize that this threshold represents an average for drinkers generally. It is not necessarily safe for everyone to drink up to such a level, nor does it follow that everyone who exceeds the level will suffer ill effects. There are many differences among individuals in the long term effects of alcohol on health. Unfortunately, it is not yet possible to predict on an individual basis who will be adversely affected and who will be spared. The wisest course is to assume that your chances are not better than the average.

Heavy drinking by pregnant women carries a particularly high risk of damage to the unborn child. The abnormalities which may result are known as the "foetal alcohol syndrome". A safe level (if any) has not yet been determined. Therefore, it may be advisable to avoid alcoholic beverages altogether during pregnancy.

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The Journal is published monthly by the Addiction Research Foundation, 33 Russell Street, Toronto, Canada. M5S 2S1

Study profiles substance abuse by women

Backgrounder

By Harvey McConnell

WASHINGTON — American women who seek treatment for drug and alcohol problems reflect only a small public view of the much larger numbers who are in trouble but hidden from sight.

There is no question that millions of women are affected, even though there are no precise measurements or overall figures, according to a report on drugs, alcohol, and women's health prepared for the National Institute on Drug Abuse.

The report, compiled for NIDA by private consultants, is a distillation of data provided by a nationwide alliance of people from public and private groups. Muriel Nellis acted as national coordinator and is principal author.

Ms Nellis says that although the report "should not be construed as scientifically definitive" there is a striking consensus on problems and recommendations.

The report says the magnitude of the problem is suggested by a number of different statistics, observations, and local surveys:

- Statistics show 60% of psychotropic drugs, 71% of anti-depressants, and 80% amphetamines are prescribed for women.
- Alcohol abuse is involved in 20% of all divorces.
- Girls have the larger percentage increase in studies of teenage drinking.
- There is an increasing rate among women of deaths from cirrhosis.
- The estimated 10 million Americans who are alcoholics are divided equally between women and men.

The report says: "Drug and alcohol abuse appear to cut across all economic, social, racial, and cultural boundaries, but many — perhaps the majority — of women substance abusers are 'hidden'.

"They do not become 'statistics' until confronted by a crisis that forces them to seek help.

"The stigma attached to the use of drugs or alcohol by women makes it difficult for them to admit their problem and seek help, be rehabilitated and then accepted by society."

Women can more easily hide substance abuse as they are often alone throughout the day. Because of the stigma attached to abuse they are either sheltered by families and friends or do not seek treatment.

The report says polydrug abuse and cross-addiction is a significant problem. One study found 80% of women alcoholics reported they used other drugs as frequently as alcohol.

Women who are middle-aged and middle-class are susceptible to prescription drug abuse. Medications are often provided to help them "cope."

The report finds 80% of prescriptions for mood-altering drugs are written by specialists, general practitioners, and obstetricians and gynecologists, and who have had no training in psychopharmacology. In contrast, only some 9% of psychiatrists write similar prescriptions.

There are few data on alcoholism and working women. The report says this is because the symptoms — irritability, somatic complaints, and fatigue — "are vague and nonspecific and women who tend to have low-paying positions are easily replaced if they fail to perform."

The report says the most consistent recommendation it gathered is for the provision of comprehensive health services for women by better coordination of the existing systems and resources.

"As currently provided, services are fragmented, sometimes overlapping, but more often leaving wide gaps. They are neither comprehensive nor widely available, show a tendency to 'treat' a problem in isolation, typically ignoring total needs."

The report calls for expanded research on a number of issues. Studies should include:

- An assessment of the relationship between substance abuse and such factors as isolation, family violence, moving, divorce or separation, employment, and education.
- Identification of specific "risk factors" for such vulnerable groups as teenagers, pregnant women, minority women, housewives, single mothers, divorced or separated women, and women living in ghettos or rural areas.
- A search for warning signs of actual or potential abuse so that intervention can be made.
- Finding techniques for coping with such possible crises as marriage, parental responsibility, unwanted pregnancy, abortion, rape, menopause, divorce, widowhood or major surgery.
- Accurate assessment of the impact of advertising and marketing techniques on the use of alcohol and prescription and over-the-counter medications.
- Identification of the relationships between hormonal changes in a woman's life and the use and effects of drugs and alcohol.
- A determination of the relationship of the menstrual cycle on drug and alcohol metabolism.
- An examination of the effect of prescribing patterns by doctors and the abuse of prescription drugs.

The report finds, in contrast, some striking omissions in the data it gathered from the alliance members.

One was smoking. "The subject was not mentioned, despite the fact that women are rapidly approaching parity with men in the incidence of lung cancer and emphysema."

There was also no mention of marijuana, and possible health implications of frequent use by women, or of obesity.

The report calls attention to the advertising and promotion among doctors of sedatives, tranquillizers, and mood-altering drugs.

These "portray women as anxious, depressed, in need of a medical 'crutch' to deal with their problems, and thus reinforce the tendencies of physicians to prescribe such drugs for those problems."

Doctors can inadvertently encourage dependence on drugs by allowing repeat prescriptions. At the same time, doctors fail often to identify alcohol or drug problems in women.

The report adds: "Their lack of sensitivity can be traced to their medical education, where little emphasis is placed either on problems which have implications for the health of women or on alcohol and drug abuse.

"Physicians are taught to treat symptoms, rather than to identify underlying problems, and are conditioned to believe that women are not as psychologically 'sound' as men, are inherently more dependent and likely to have emotional problems."

Medical schools should include women's health problems and drug and alcohol abuse in the curriculum.

The pharmacist has an important role to play.

The report states: "Pharmacists are in a unique position to identify women who refill prescriptions frequently, or who are taking drugs that may be cross-addictive. They can also distribute information about drugs, side-effects and substance abuse."

When women do reach the point of receiving treatment for drug or alcohol abuse it is often "limited and often ineffective because it ignores their physical, psychological, and social needs."

Bureaucratic and therapeutic rationales are used to separate the needs of the woman drug addict and the woman alcoholic; alcoholism is considered a "disease" while drug problems are considered a "self-imposed addiction."

The report calls for Congress to set up a commission on the causes and implications of substance abuse among women. If Congress chooses not to act, then the President could set up a commission by executive order.



Muriel Nellis

Naltrexone shows promise in heroin addiction

Inside Science

By Richard A Rawson, PHD and Michael Glazer, MA

The use of narcotic antagonists as a treatment modality for heroin addiction has long appeared to be a promising approach for the treatment of heroin addiction.

Narcotic antagonists are a class of drugs which block the effects of opiates such as heroin and morphine. The treatment strategy for these drugs is to keep addicts heroin-free by maintaining them on an antagonist while lifestyle changes occur which will result in permanent heroin abstinence. It was postulated that if an antagonist could be developed which provided at least a 24-hour opiate blockade with minimal side effects, a major step forward would be forthcoming in the heroin addiction treatment field.

Unfortunately, there were some problems with the early antagonists which made the successful application unrealistic. Cyclazozine, one of the first antagonists to be tested clinically as a maintenance drug, produced an opiate blockade for an adequate period of time and demonstrated initial promise as an addiction treatment. However, further testing indicated that some patients experienced unpleasant feelings described as dysphoria and psychotomimetic effects, which resulted in refusal to continue use of the drug. Naloxone, a pure antagonist, had few unpleasant side effects, but the duration of the opiate blockage produced was too short for practical use on an outpatient basis.

With the development of naltrexone, it appeared that the perfect antagonist drug had been developed. A 50 mg oral dose of naltrexone produced a 24-hour opiate blockage against all opiate effects. Even more important clinically, a 150 mg dose produced an opiate blockade for over 72 hours with few noxious side effects. Naltrexone clearly had all of the characteristics of the perfect antagonist for the treatment of heroin addiction.

In May, 1976 at a NIDA (National Institute on Drug Abuse) sponsored conference in Richmond Virginia, the preliminary evaluations of naltrexone were presented by all investigators using naltrexone. With few exceptions, the results were surprisingly poor. Most investigators found it difficult to interest a substantial number of addicts in naltrexone treatment, and of those who started naltrexone, a high percentage quickly discontinued treatment. The majority of reports suggested that naltrexone was pharmacologically a highly effective drug, with few side effects, but that it would have limited usefulness because only a few highly motivated addicts would use it for a clinically significant period of time.

One exception to this view was the report based upon the preliminary results of the Heroin Antagonist and Learning Therapy (HALT) Project, which predicted a more optimistic future for naltrexone. The early data from the HALT Project suggested that in the proper therapeutic context, naltrexone could be a viable treatment modality for heroin addiction. This report was based upon one year of naltrexone use at the HALT Project, a UCLA (University of California, Los Angeles) sponsored, NIDA funded outpatient clinic located in Oxnard, California. The addicts treated in this clinic were primarily Chicanos and Anglos who had been addicted for an average of eight years.

The final results of the HALT Project are even more promising than the 1976 report. The project, which was initially designed to treat 40 addicts with naltrexone, started 43 clients on the drug. The mean treatment duration for these 43 clients was 29 weeks. Sixty-eight percent of these clients stayed in treatment for over 24 weeks. During treatment, the clients gave 94% heroin free urine samples. Although only 20% of these clients were employed at intake, more than 75% were employed after eight weeks in treatment. Most importantly, one year post-treatment follow-up urine samples (which were collected from 37 of the 43 clients) indicated that 18, or 49%, were heroin-free. It should be noted that the number of addicts treated with naltrexone at HALT was limited by staff size.

The HALT project results with naltrexone suggest it is a promising treatment modality for heroin addiction. However, these results are at odds with most other reports evaluating the clinical usefulness of naltrexone. As has been noted by Dr Avram Goldstein, many investigators continue to feel that naltrexone's usefulness is limited by the small number of addicts who are willing to start the drug, and by the high drop-out rate.

The reason for the disparity between the results obtained by HALT and those of other investigators is unclear. However, the clinical approach used by HALT may have been a critical factor in the success of the program. The treatment rationale was based upon the following set of priorities:

1. Establish a close rapport with the clients and remove as many practical obstacles as possible (including detoxification) in order to facilitate naltrexone induction.
2. Keep the client on naltrexone. This often required home deliveries of the drug, dispensing arrangements at local pharmacies, and seven-day-a-week, 24-hour-a-day availability of the drug.
3. Provide a "real" opportunity for employment. Many clients need training in the skills required to obtain and hold a job before being referred for job placement. Also, aid in transportation to and from the job was often necessary for short periods of time.
4. Provide goal-oriented behavioral counselling. For many clients, assistance in locating adequate housing was more relevant to treatment outcome than in-depth psychotherapy. Although instances occurred where intensive therapies were required (and provided), situations where assistance in finding day care facilities, working out employment disputes, and structuring leisure time activities, were of a greater need.

In summary, more research must be done on how more effectively to use naltrexone as a treatment modality for heroin addiction. Much effort has been spent in producing this highly effective pharmacological agent. Effort is now needed to develop clinically effective modes of naltrexone delivery. Naltrexone *can* be effective. The present need is for clinically effective and efficient naltrexone treatment delivery systems.

Richard Rawson is principal investigator of the HALT Project. Michael Glazer is a co-worker on the project.

Hong Kong's drug fighters see signs for optimism

By Lachlan MacQuarrie

HONG KONG — Drug fighters here are cautiously optimistic they may be starting to contain Hong Kong's drug problem — one of the most serious in the world.

The continuing decrease in the incidence of heroin addiction among young people, and the spiralling increase in heroin prices are among the significant indicators of a decreased drug problem.

These observations were made in the annual *Narcotics Report* of the Action Committee Against Narcotics (ACAN), a high powered committee set up as the sole advisory and coordinating body for the government on all matters relating to the eradication of drug trafficking and abuse, including the allocation of resources for control, treatment, rehabilitation, and prevention programs.

ACAN was set up in 1964 and more strongly reconstituted in 1974 in an attempt to deal with a drug problem deeply rooted in the historical, social, cultural, and economic fabric of Hong Kong.

The exact number of addicts in this densely populated city of 4.5 million is not known, but estimates have varied between 60,000 and 100,000. Most use heroin, and on the average an addict uses 0.2 grams per day. Taking the lowest figure of 60,000 addicts and prevailing heroin prices, ACAN has estimated addicts have paid HK$610 million (about Canadian $152 million) per year for drugs.

But now, states the *Narcotics Report:* "There is increasing evidence that internally, Hong Kong has reached the stage at which it is containing the overall problem and is achieving marked success in preventing the spread of drug abuse to young people."

Records of the three major treatment programs, The Prisons Department's Addiction Treatment Centres, the Society for the Aid and Rehabilitation of Drug Addicts (SARDA), and the Medical and Health Department's methadone maintenance and detoxication programs point to a steady decline in the number of young people involved in drug abuse.

In 1969, 25.4% of all addicts treated in the Prisons Department compulsory rehabilitation program were under the age of 21. In the years since that time the proportion of addicts under 21 treated by the Prisons Department has declined steadily to a 1976 figure of 8.6%, or 186 of a total of 2,160 addicts treated.

In 1969, 12.5% of those treated in the voluntary rehabilitation program operated by SARDA's drug free island centre were under 21 years of age. In 1976, this proportion had dropped to 4%.

Addicts under 21 made up only 2.5% of the total registration in the relatively newer methadone programs of the Medical and Health Department which currently serve about 5,200.

The chairman of ACAN, Dr the Honorable Sir Albert Rodrigues, attributes these developments in part to successes of Hong Kong's law enforcement agencies, "in so restricting illegal drug supplies and in raising traffickers outlays, that drug prices were driven to an all time high."

He also pointed to "major advances in our thinking and efforts on prevention, education and publicity" and to the resulting preventive strategy which included as its four main objectives, "to win public support in combatting the drug problem, to prevent young people from experimenting with drugs, to encourage existing addicts to come forward and receive treatment, and to inform the international audiences of Hong Kong's intentions and progress in the anti-narcotics field."



Hong Kong has now reached the stage where it is controlling the overall drug problem and preventing the spread of drug abuse to young people.

The ACAN report, however, cautions against complacency. "The patterns of trafficking and drug abuse are constantly shifting internally and externally, and we must be alive to the possibility of new initiatives by those who feed on, and profit by, this evil trade."

Destination of seized opium worries Turks

NEW YORK — Turkey, now a licit supplier of opium, is concerned at reports that seizures of illicit quantities of the drug are being sold to pharmaceutical companies at a cut-rate.

Ilter Turkmen told the United Nations Economic and Social Council meeting here the reports are as yet unconfirmed:

"If they prove to be correct, a considerable amount of illicitly produced opium will thus be made available on the world market during the current year. This will certainly affect the precarious balance of supply and demand."

Mr Turkmen said it has also been reported that in parts of the world where illegal drug trafficking is most critical, some countries are contemplating the construction of alkaloid factories.

He added: "These potentially dangerous practices and projects not only constitute an unjustified attitude towards the legal producers of opium, but it would also encourage illicit cultivation and illicit trafficking."

Drug abuse control and the battle against illicit trafficking must be a cooperative international venture, and can only be successful if every member of the international community shoulders a share of the responsibility.

"It is, therefore, surprising to note the tendency of expecting more sacrifices from the legal producers to assure the world supply and demand balance," he continued.

"There are a number of countries where illicit production of, and illicit traffic in, opium and cannabis are at an alarming level.

"They should be assisted further and encouraged in their efforts to stop illicit production, instead of devising new ventures amounting to granting an illicit and uncontrolled production operation the status of licit production and, thereby, delaying a final solution."

Mr Turkmen said his country is now training additional narcotic agents, especially for the customs service. With help from the United Nations Fund for Drug Abuse Control, planes are now being used to help on border patrols.

In addition, his country is vigorously pursuing co-operation with its neighbors.

A protocol for cooperation signed between Turkey and Syria in 1966 has been used as a model for an agreement signed last year with Egypt. Similar agreements are now under consideration by Iran, Yugoslavia, Bulgaria, and Greece.

Around the World

Milkmaids

Drunk and disorderly milkmaids are reducing milk production at the Sudnikovsky State farm 60 miles west of Moscow, according to the newspaper *Banner of Lenin*. The paper said farm director N. F. Strukov tried to make everything look normal when he knew a reporter was coming. But Mr Strukov was betrayed by farm workers who complained about conditions.

Diplomacy

More than 30 foreign diplomats were arrested in London, England last year for alleged drink-and-drive offences, and none were prosecuted, according to the police and Foreign Office. Some of the arrested claimed diplomatic immunity. The Foreign Office said: "In each case we drew the attention of the ambassador concerned to the incident and asked him to discuss it with the diplomat." Ambassadors were told that a repetition of such an incident would be viewed seriously.

English garden

Mushrooms and their hallucinogenic properties are creating a legal tangle in British magistrates' courts. During the past 18 months, more than 50 people have been arrested for possessing psilocybin mushrooms. Courts, with only a few exceptions, have then been regularly acquiting these same people because the law is confused about whether the half-dozen species of hallucinogenic mushrooms growing in Britain are illegal.

'Dry' Campaign

The move by India's prime minister to make the country totally 'dry' has run into trouble in Goa, the former Portuguese enclave on the south west coast, where an anti-prohibitionist campaign has been launched. Initially set in motion by the tiny state's brewers and distillers, the campaign has received support from unexpected quarters. The Archbishop of Goa has resigned from the dry prohibition committee and asked the committee whether it will make a "true" study on the feasibility of prohibition.

Coffee bars

Modern, attractive coffee bars manned by church people should be opened until the early hours of the morning in England as an alternative to taverns, according to a spokesman of the Temperance Council of the Christian Churches.

Proper crop substitution 'rewarding'

NEW YORK — Crop substitution aimed at stemming narcotic production, to prove successful, must be carried out on a regional basis and work within the context of social and economic development.

Garvey Laurent, of the United Nations Food and Agricultural Organization, told the UN Economic and Social Council meeting here crop substitution "has already proven itself rewarding" when applied under these circumstances.

He said the FAO has been associated closely with the Thai government in a program in 35 villages around Chiengmai in the Golden Triangle area of Southeast Asia.

"Additional evidence corroborating the soundness of this approach is now expected from Burma.

"There, training of selected young farmers, the use of appropriate farm equipment, adequate marketing, research, and demonstrations, are combined with education, social welfare, and law enforcement to help effect the gradual shift of the pattern of land use away from the traditional growing of narcotic crops."

The government of Laos has started a similar program, and an agricultural program along these lines in Pakistan is now in the pilot stage.

An important element in all the projects "is the attainment by farmers of a high degree of conviction of the desirability of abandoning drug crop production."

At the same time, there has to be swift geographic coverage of technical cooperation.

Mr Laurent said the FAO emphasizes training as not only essential for progress within a country "but also for an eventual intraregional transfer of knowledge, experience, and appropriate technology.

"It is unrealistic to expect to achieve narcotic crops eradication in individual countries operating in isolation from their neighbors."

'Amend cannabis policy'

NEW YORK — The Netherlands government would like to see the 1961 United Nations Single Convention on Narcotic Drugs altered as it applies to the personal possession of cannabis.

E. J. N. Brouwers, in a report to the United Nations Economic and Social Council meeting here, said in his country "it is felt that the use and possession of cannabis for other than scientific and medical purposes should no longer be subject to the penal law.

"However, since the Netherlands is a party to the Single Convention on Narcotic Drugs, it is not yet possible to reach this policy goal."

Mr Brouwers said the Netherlands would like to see the convention amended "so as to enable each party to determine for itself the extent to which cannabis may be allowed for personal use, provided that each party strives to prevent distribution and prohibit the export and production of drugs for illegal use in other countries."

He emphasized the government did not think the use of cannabis is devoid of any personal or social risks.

Swedes tackle drug abuse

NEW YORK — A nine-point comprehensive nationwide program to deal with the problems of drug abuse in Sweden is expected to be adopted soon by the government.

Johan Nordenfelt told the United Nations Economic and Social Council meeting here the new proposals accept the fact the results of current treatment programs are uncertain.

"This stage of affairs can no longer prevail, and an ambitions program for a scientifically adequate evaluation of treatment is to be launched," he added.

One of the major points in the new program will be for care and treatment of young addicts in their family home, plus adequate financial support.

Public in dark about controlled drinking option

By Alan Massam

LIVERPOOL, ENG — The view that complete abstinence should be the goal in alcoholism treatment has been challenged by a clinical psychologist.

Nick Heather told the 4th International Conference on Alcoholism here, that it is now fully 16 years since a small, but significant proportion of diagnosed alcoholics were found able to drink normally after being treated in therapeutic regimes directed at total abstinence.

"As we know, the evidence for this finding has recently become extremely controversial once more, following the publication of the so-called Rand Report*," he said.

No criticisms (of the Rand Report) so far made are sufficiently damaging to invalidate the particular conclusion in respect of resumed normal drinking or to warrant a wholesale rejection of the report as methodologically inadequate, said Mr Heather of Scotland.

"Indeed, by the standards of research into alcoholism, which admittedly are low, the report is a highly competent piece of work given the unavoidable limitations of a field survey."

Mr. Heather said since 1962 — whether consciously intended or not — the public had, to a large extent, been denied access to information about the normal drinking of some recovered alcoholics.

"That this effort continues is perhaps shown by the fact that the Rand Report was condemned at a specially convened press conference by the organization which had originally commissioned it (US National Institute on Alcohol Abuse and Alcoholism) and that copies of the report are now extremely difficult to obtain," he said.

"Of course, the argument which is often made for suppressing the finding of resumed normal drinking is that this knowledge is dangerous because recovering alcoholics, to use the terminology of Alcoholics Anonymous, might be tempted to begin drinking again, and, assuming the AA principle of "one drink, one drunk,' might relapse into alcoholism."

Mr Heather said the extraordinary thing was that this was the same reaction as that to earlier reports of resumed normal drinking. He said there was evidence to suggest, however, that knowledge of the existence of resumed normal drinking was not as dangerous as some might suggest; although it was dangerous that legitimate scientific studies should have been suppressed.

He reminded the audience of the Pythagoreans, the ancient mystical sect whose priests derived authority from their special knowledge of perfect numerical ratios. One priest discovered the phenomenom of "irrational" numbers — thereby accelerating considerably the progress of mathematics — but was forbidden by his colleagues to make the knowledge available to the laity. The priest's commitment to truth overcame his fear of the consequences so he revealed his discovery and was duly executed.

"The suspicion strongly remains, of course, that in attempting to keep the existence of irrational numbers secret, the Pythagorean priests were less concerned with the bemusement such knowledge might engender among the populace than with the grave threat it posed to their own authority," Mr Heather said.

He added that the remarkable thing about patients who recovered the ability to drink normally was that they succeeded in so doing in spite of their treatment, for they were thus ignoring their doctors' advice, and, if exposed to AA teaching, achieving something repeatedly said by "recognized authorities" to be absolutely impossible.

"This immediately raises the question of how many more successful attempts at control of drinking might occur if patients were not discouraged from but actually assisted in the pursuit of moderate drinking.

"The important point here is that I find no reason to concede as yet that controlled drinking methods are only applicable to the less serious problems of dependence on alcohol."

**Alcoholism and Treatment, The Rand Corporation, Santa Monica, 1976.*

Forced retirement an injustice for many elderly alcoholics

By Jean McCann

ST LOUIS — Forced retirement of the older alcoholic is just one of the major injustices perpetrated against the elderly with drinking problems, Eloise Rathbone-McCuan told the National Council on Alcoholism meeting here.

"When alcohol-related problems such as tardiness, absenteeism, and poor job performance surface, the policies of some companies are to force the older worker to take optional retirement," Dr McCuan said. "This may appear a face-saving action for the person, or an economically reasonable response for the company, but it is not helpful to the older alcoholic worker.

"Forced retirement may reduce self-esteem, it may force the older person into a style of life where his alcoholism problem is intensified, and it may remove him from possible contact with alcoholism counsellors available through the organization.

"It may also cut him off from health benefits which could cover the cost of proper and comprehensive treatment", said Dr McCuan, of Washington University in St Louis.

By firing him, the company forces him often to rely on the limitations of Medicare and Medicaid treatment which may restrict frequency and duration of treatment. Furthermore, the older person is often unaware that any such coverage is available, since Medicaid and Medicare workers in the United States are often poorly informed themselves.

Other examples of "Ageism" against the older alcoholic, Dr McCuan said, include:

- The rarity of the availability of alcohol treatment in the same setting in which other chronic conditions faced by the elderly are treated;
- The rejection-promoting behaviors of both medical and social service professionals, which "cannot help but influence the individual's help-seeking behavior," and since both alcoholics and the aged generally suffer from low self-esteem, the combination in one person can be devastating; and
- Overprotection by adult children of the older alcoholics, which encourage an unnecessary, unhealthy dependency attitude in the aged person.

Dr McCuan said it is important in treating the older alcoholic to include the spouse, if there is one. The spouse may benefit from Al-Anon, she added, although "the age difference between the spouse and others who attend may establish a generation gap."

Common fears of the spouse of the older alcoholic should be discussed, she said. These include a sense of financial insecurity enhanced by spending precious funds on alcohol, and fears the alcoholic spouse will lack care when their own health fails.

She said that considerations of the older alcoholic and spouse family situation are quite different from the usual "nuclear family" concept used in family therapy. There shouldn't be an assumption that child rearing is a significant function of this older family, for instance. However, input of older, adult children should be a consideration. This is especially true since some adult children will inappropriately "rescue" their parents from the consequences of their alcoholism, so that the latter do not learn to overcome it.

On the other hand, the older alcoholic may have "turned off" family members over a long period of erratic behavior, and so may no longer have their emotional support, she said.

In a study of the cases histories of older alcoholics treated in a small St Louis hospital, Dr McCuan said "most of the older alcoholics and problem drinkers treated in this setting had spouses and adult children who had been greatly affected by the disease of alcoholism", and often this had resulted in a disengagement early in the family's history.

However, too often those treating the older alcoholic assume this is a permanent disengagement, when this may not be the case, she said. It is not wise to assume that attempts to involve adult children will prove fruitless.

Another important point in assessing the older person's ability to remain sober after treatment, is assessment of his or her home base, and to that end a home visit is a necessity, she said. "This should be a standard component of the evaluation and screening for all older alcoholics," to understand both living arrangements and the psychosocial supports available to that person.



Drunken Liverpool fans left a trail of destruction recently when they returned to England following a European Cup match in Hamburg. Club directors are drawing up a list of troublemakers to prevent a recurrence.

Drunken soccer fans blacklisted

LIVERPOOL — Directors of Liverpool, one of Britain's and Europe's top soccer clubs, are taking stringent steps to prevent drunken fans from following them when they play games away from home.

Fans left a trail of destruction when they returned recently from West Germany to England following Liverpool's European Cup match in Hamburg. A duty-free liquor store on a ferry from Ostend, Belgium, to Dover was looted bare.

Drunken youths are a common sight every Saturday on the terraces at almost any British soccer club. In the last few years, drunken British fans have earned a terrible reputation in Europe for their behavior.

John Smith, Liverpool chairman, said the club will draw up a blacklist of troublemakers, identity cards will be issued to fans for foreign trips, and a ban will be sought by British Rail for cheap excursion trains to European matches.

The blacklist will hit hard, as almost always it is only through the club that a fan can get a scarce ticket to a European Cup match.

Mr Smith said: "We are determined to do everything possible to uphold the good name of the club. Supporters who cause trouble, even if they don't appear in court, will go on the blacklist."

Checks urged on 'sport doping'

LONDON — Ministers of sport in all the Western European countries have been asked by the International Sports Federation to help establish centres to test for drug use among amateur athletes.

Charles Palmer, secretary general of the federation, says only governments have the money needed to set up drug testing units.

"It is costing more than one million dollars for a dope control unit at Lake Placid for the 1980 Winter Olympics. Individual sports have no hope of raising that kind of money.

"We need the facility from individual governments wherever and whenever it is necessary."

Mr Palmer said no more than 12 centres are needed around the world "to bring most types of sport doping under control."

Denis Howell, Britain's minister of sport, has asked his European colleagues to provide laboratories to test athletes for drugs.

Cigarette smugglers stunned

DOUAI, France — Two Britons who admitted smuggling 848 cases of cigarettes from England to France have been fined a staggering $2,700,000 and sentenced to 18 months imprisonment by a French appeals court.

Martyn Dance, a truck driver, and Eric Jenkins, a plumber, were caught at Calais by French customs officials. The cases contained eight million cigarettes.

Mr Dance said he had made 11 previous trips and smuggled successfully cigarettes worth $30 million past customs. Both men claimed they were not racket kingpins and were paid only $300 for each trip.

A lower court had sentenced them originally to four months in prison and a smaller fine, but they made the mistake of appealing to a higher court. Under French law, an appeals court has the right to increase a sentence if it deems fit.

French legal officials said the fines are calculated on the customs' duty evaded by the smugglers and are usual in such cases. However, in most instances authorities will agree to accept a lower figure.

Mr Dance's troubles will not be over when he leaves France: he is wanted in Britain on three charges.

President Carter is urged to raise research funding for alcohol and drug abuse

WASHINGTON — A modest increase in American government spending on research into alcohol and drug abuse has been recommended by the President's Commission on Mental Health.

In its report to President Carter, the commission says: "Alcohol abuse is a serious social, physical, and mental health problem. About 10 million people report having experienced recent alcohol-related problems."

Alcohol research spending should go up $9 million, to $30.2 million in the next fiscal year and drug abuse research by $9 million, to $55 million, the commission suggests.

In its overall study of mental health care — one of every seven Americans is estimated to need some form of care — the commission calls for federal grants totalling $275 million over three years to increase the number of community mental health system centers in the country.

It says a plan should be devised to close large state mental institutions, to include mental health care in any national health insurance program, and to increase federal investment in training and research.

More specific recommendations in the field of alcohol and drug use and abuse were presented previously to the commission by special liaison task panels.

Mental Health Commission says about 10 million report recent alcohol problems

The panel on alcohol-related problems was coordinated by Peter Brock, of Group Health Association of America, Inc, Washington. The panel on psychoactive drug use/misuse was coordinated by Dr Norman Zinberg, of Harvard Medical School.

The panels submitted separate reports and recommendations but made three joint proposals:

- Formation of a federal commission on alcohol and psychoactive drug use.

The commission should focus on "psychoactive drug prescription practices, risks related to alcohol consumption and alcohol in combination with other drugs, and related concerns with illicit psychoactive drug use."

- A review of the quality of treatment for dysfunctional users of both alcohol and psychoactive substances.
- Inclusion of coverage for the treatment of the dysfunctional problems associated with psychoactive drug use and alcohol in comprehensive health insurance programs.

In its report, the panel on alcohol-related problems said a national commission could recommend "an integrated national alcohol problems prevention and treatment policy to both the President and the Congress."

Under any national health insurance plan "the treatment of alcoholism, and of the problems of the family of the alcoholic, should be categorically covered at a level no less than that of any other illness."

Adequate resources should be committed to devise, implement, and evaluate prevention strategies with the realization "such strategies require long term allowances for effective evaluation."

Funds for research on alcoholism and alcohol-related problems should be at least $30 million for fiscal 1979, and in future years spending should be "commensurate with the need for sound policy and planning efforts."

Policymakers and those who provide services need "greater sensitivity" in dealing with special groups. The panel said these include women, young people, the disabled, the aged, homosexuals, migrant workers, children of alcoholics, and minority ethnic groups.

There is a need for quality assurance programs which should be "oriented toward clients rather than providers."

In its report to the commission, the panel rejected any idea at present of merging the National Institute on Alcohol Abuse and Alcoholism (NIAAA), the National Institute on Drug Abuse (NIDA), and the National Institute on Mental Health (NIMH).

Any administrative merger "could seriously undermine the progress made to date in the visibility, degrees of acceptance as a valid public health problem, and generation of support among both policymakers and the general public for efforts to reduce alcoholism and alcohol-related problems."

The panel said there should be a close examination of the amount and disposition of taxes on beverage alcohol.

It pointed out that in the US the prices of alcoholic beverages relative to other commodities have decreased considerably in the last 30 years, and taxes on alcohol have not risen proportionately to the rise in the cost of living.

The panel said there are public health aspects of the alcohol tax rate which merit careful consideration.

It declared: "A modest earmarked tax on alcohol would provide a permanent base of support for treatment and prevention of alcohol problems.

"Since heavy drinkers account for such a large portion of the total consumption, they would, in effect, be funding the attendant social costs."

The panel found that at present there is no national alcohol prevention policy and "there is not even a minimal resource commitment at the federal level that would allow the beginning development (sic) of such a policy.



Jimmy Carter

"The demand for treatment services has captured almost every available federal dollar except for those secondary prevention efforts, such as occupational programs, that are basically treatment oriented."

The panel recommended that the prevention budget for NIAAA be increased substantially.

On the research side, the panel said more emphasis should be given to factors which contribute to alcohol-related phenomena: cultural drinking patterns, social policy, and public attitudes with respect to alcohol use.

In the treatment field, the panel said: "There is no discernible comprehensive treatment network or system that would ensure both availability and accessibility of treatment services, even in minimum quantity or quality, in a consistent manner across the country."

The government has responded to demand, but often it has been to demands most articulately expressed by groups and organizations within the health and mental health care system.

These skills "in attracting the federal dollar were often greater than their skills in accounting for the use of that dollar in rendering quality care to alcoholics."

The panel called for strict accounting because "experience demonstrates that regulatory control of alcoholism treatment funds is essential if they are to be utilized effectively."

In a long report, the panel on psychoactive drug use/misuse made a number of recommendations.

Psychoactive drugs panel wants clear distinction made between patterns of drug use

It called for "all possible efforts to be made legally, medically, and socially to make distinctions between that psychoactive drug use with minimal social costs — experimental, recreational and circumstantial — and the more dysfunctional intensified and compulsive use patterns."

The most important and immediate goal is full implementation on state and federal level of moves to decriminalize personal possession and use of small amounts of marijuana.

When this has been achieved the panel believes decisions should be made on taxation, regulation, and control of marijuana.

These decisions should include the setting of standards of purity, limits on individual cultivation, prohibition of advertising, promoting marijuana use, setting a legal age for purchase, and the setting of penalties for driving under the influence of marijuana.

The panel asked for creation of an independent advisory committee to make a fundamental reappraisal of the quality of drug treatment services in America.

As for drug education and prevention strategies, the panel said these should "be aimed at the avoidance of the destructive patterns of psychoactive drug use,



Norman Zinberg

and an immediate cessation be imposed on the development of materials and programs aimed exclusively at prevention of all use."

Insistence on material "aimed at abstinence and drug-free behavior has promoted distrust and disbelief of all drug information disseminated by government, schools, and other social institutions.

"Paramount to education and prevention strategies should be the development of responsible and informed decision-making regarding the use of psychoactive drugs and the avoidance of the deleterious consequences of such use."

Education and prevention efforts, the panel said, should be joined with those of alcohol and tobacco "since they are the first two psychoactive substances used by most individuals."

The panel said the federal research focus should "view psychoactive drug-using behavior as a socially evolving process, imposing its own constraints and limits on the majority of the using population."

Future research should be organized to reveal those commonalities between the chronic use of psychoactive drugs and other drug and nondrug habitual behavior patterns, such as with alcohol, tobacco, and gambling.

The panel called for the Drug Abuse Warning Network (DAWN) to be administered by NIDA instead of the Drug Enforcement Administration as at present.

A committee from the private sector should be formed "to organize and develop the mechanisms to offer comprehensive responses to the issues of psychoactive drug use."

With the demise of the Drug Abuse Council there is now no organization to monitor government programs and expenditures.

The panel said in its opinion "the overwhelming majority of users of psychoactive drugs of all kinds are experimental, recreational, or circumstantial, and present little problem, either to themselves or to others.

"A much smaller group of users could be classified as intensified and the smallest group as compulsive."

The panel does not want to say "all experimental or recreational use of some drugs are risk-free. Drugs are qualitatively different from one another in terms of individual and social risks."

The panel made a number of observations about several of the most used drugs:

- **Heroin:** "Recent indications are . . . that the use of heroin may have been considerably underestimated, with the number of individuals using heroin occasionally, functioning in socially approved manners, and failing to exhibit dependent behaviors, far exceeding those exhibiting classically dysfunctional behavior."
- **Cocaine:** This drug is rapidly becoming the drug of choice for younger adults despite its high cost and limited availability. "The health and social consequences of cocaine use under various routes of administration, differing potencies, and frequency of use are widely disputed."
- **Hallucinogens:** "The hallucinogen scare stories of the 1960s have given way to more reasoned assessments of the effects of the drugs."
- **Marijuana:** "Marijuana usage is accepted behavior by large segments of our younger population and its general acceptance into the culture appears to be only a matter of time."

Further research is needed on various long term approaches to opiate dependence

In the research field, the panel said efforts should be devoted to an evaluation of the efficacy of different modes of treatment on the variety of drug-related client dysfunctions.

"Further research is needed on a variety of long-term approaches to the treatment of opiate dependence, including methadone maintenance and other opiates for induction and as adjuncts to treatment, and long-acting narcotic antagonists such as depot naltrexone."

Research is increasing into the possible therapeutic efficacy of some illicit psychoactive substances. "However, these research efforts are still hampered by bias and bureaucratic morass."

Unreasonable bureaucratic obstacles for medical use of these substances should be removed, the panel said.

NEW MATERIALS FROM ARF

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P-151 **DIAGNOSIS AND TREATMENT OF ALCOHOLISM FOR PRIMARY CARE PHYSICIANS** **$1.95**

A 36 page handbook on alcoholism developed for the primary care physician in conjunction with the Ontario Medical Association. A "how-to" guide dealing with identification, diagnosis, short and long-term management in both the medical and psycho-social senses. Invaluable to the medical practitioner.

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BOOK

A SYSTEMS APPROACH TO ALCOHOL TREATMENT

Authors: Frederick B. Glaser, M.D. **$14.95**
Stephanie W. Greenberg, M.A.
Morris Barrett, M.P.H.

A major work which provides the results and conclusions on the system of alcoholism treatment programs within a large geographic area. The book provides a factual base from which to proceed toward developing a systematic alcoholism service delivery program. Will be of interest to administrators, organizational and policy personnel, and the general health care professional.



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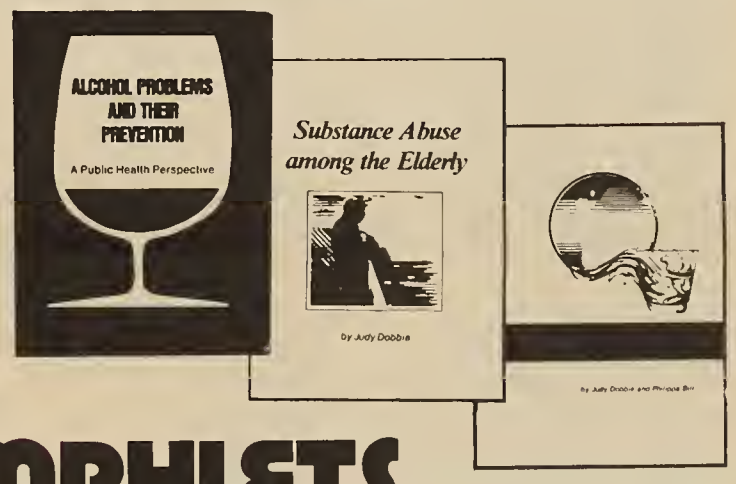
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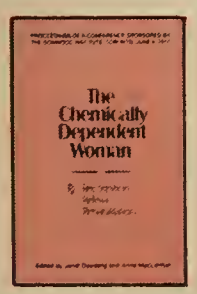
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New Books

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The Care And Management Of The Sick And Incompetent Physician

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An in-depth study of the sick, incompetent, or unethical physician is presented. The significant literature is summarized, and personal experience of the authors is considered in proposing solutions. The book is divided into nine chapters, each directed toward one or more of the clinical and etiological factors involved in the development of the sick and incompetent physician. Chapters are devoted to the drug-addicted physician, and alcoholism among physicians. It is hoped that this volume will provide an impetus to better management of a growing problem within the medical profession.

(Charles C. Thomas, Publisher, 301-327 East Lawrence Avenue, Springfield, Illinois. $8.50.)

The Alcoholic Marriage: Alternative Perspectives

. . . by Thomas J. Paolino Jr, and Barbara S. McCrady

The authors analyze the problem of the alcoholic marriage from four different viewpoints: psychoanalytic, sociological, behavioral, and systems theory. Written for the advanced clinician or researcher, the text is divided into seven chapters and four appendixes. Through their review of the literature, and their logical arguments, the authors refute the notion that spouses of alcoholics tend to be psychologically disturbed, and they demonstrate how the four models of human behavior can be applied to any aspect of normal or abnormal behavior, either alone or in combination.

(Grune and Stratton Inc, 111 Fifth Avenue, New York, NY, 10003. 1977. 223p. $14.50.)

Research On Smoking Behavior

. . . edited by Murray E. Jarvik, Joseph W. Cullen, Ellen R. Gritz, Thomas M. Vogt, and Louis Jolyon West.

This monograph, NIDA Research Monograph No 17, is derived from papers presented at a conference on smoking behavior convened at the University of California at Los Angeles, June 24-25, 1977. Twenty-three contributors are represented in this volume which deals with epidemiology, etiology, consequences, and behavioral change. The scope of the papers varies from the basic opponent process theory to the activist prevention policy; from differing synoptic views to particular cost figures.

(US Government Printing Office, Superintendent of Documents, Washington DC, 20402. 1977. 395p. $3.)

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six point scale. For further information, contact Linda Chung, coordinator of the group at (416) 595-6150.

The Life, Death, And Recovery Of An Alcoholic

Subject Heading: Alcohol and alcoholism overview, employee assistance programs.
Details: 25 minutes, 16 mm, color, sound.
Synopsis: Dr Joseph Pursch, a United States naval captain, gives a lecture on the stages of alcoholism by telling the story of a fictional engineer. He describes the downward path of the engineer's alcoholism, and how his dependence on alcohol has affected many areas of his life: family, finance, spirituality, mental health, occupation, and his involvement with society and the law. Dr Pursch emphasizes the cover-up that took place during his progression through alcoholism, and indicated where confrontation and intervention would have changed the story.
General Evaluation: Good to very good (4.6). A contemporary and informative film with a clear message, this film has high potential to be an effective teaching aid.
Recommended Use: Likely to benefit general audiences of 15 years of age and older; especially beneficial to health professionals and employers.

Alcohol Spots

Subject Heading: Alcohol and alcoholism overview, alcohol and the family.
Details: Seven 30-second clips, 16 mm, color, sound.
Synopsis: This series of film clips shows a male puppet in different drinking situations. Each spot conveys a message about alcohol-related problems in Ontario. The film recommends that people lower their consumption of alcohol to reduce related health and social problems.
General Evaluation: Poor (2.0). This film was considered boring, and of poor technical quality. Although it has a clear message, it lacks impact.
Recommended Use: None.

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Advertising Rates:
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M.I.P. Invites Applications for 1978-1979 Single State Agency Placements

The Minority Internship Program — a program of the National Manpower and Training System, sponsored by the National Institute on Drug Abuse, (NIDA) and operated under contract with Health Control Systems, Inc. — is inviting applications for its career mobility project to train and place 30 minority individuals into positions of responsibility with supervisory duties at State drug abuse agencies.

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How to Apply:
- Request a M.I.P. information bulletin and application form from the Director's office (same address as below).
- Mail the completed application to:
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  Health Control Systems, Inc.
  2250 East Devon Avenue
  Suite 304
  Des Plaines, Illinois 60018
  Telephone (312) 298-3260
- Applications must be postmarked by June 30, 1978, to be considered for the 1978-1979 M.I.P. Program.

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In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada, M5S 2S1.

Canada

15th Annual Meeting Of The Traffic Injury Research Foundation Of Canada — June 1, 1978, Toronto, Ontario. Information: TIRF, 1765 St Laurent Blvd, Ottawa, Ont, K1G 3V4.

Canadian Lung Association Annual Meeting — June 12-14, 1978, Winnipeg, Manitoba. Information: Hubert Drouin, executive-secretary, Canadian Lung Association, Suite 908, 75 Albert St, Ottawa, Ontario, K1P 5E7.

The College Of Family Physicians Of Canada Annual Meeting — Sept 10-16, 1978, Charlottetown, Prince Edward Island. Information: Donald Rice, executive director, The College Of Family Physicians Of Canada, 4000 Leslie St, Willowdale, Ontario, M2K 2R9.

Alberta Alcoholism And Drug Abuse Commission Summer School On Alcohol And Drugs — Sept 22-23, 1978, Kananaskis, Alta. Information: Marg Bailey, AADAC Community Extension Services, 2nd floor, 812-16th Ave SW, Calgary, Alta, T2R 0T2.

13th Annual Conference Of The Canadian Addictions Foundation — Sept 24-29, 1978, Calgary, Alberta. Information: Stuart Hutton, conference manager, Action Plan '78, 812-16th Ave SW, Calgary, Alta, T2R 0T2.

The College Of Family Physicians Of Canada (Ontario chapter) Annual Meeting — Oct 16-18, 1978, Toronto, Ont. Information: Marcia Barrett, 4000 Leslie Street, Willowdale, Ont, M2K 2R9.

Canadian Psychiatric Association Annual Meeting — Oct 18-20, 1978, Halifax, Nova Scotia. Information: Dr A. Cote, secretary, Canadian Psychiatric Association, Suite 103, 225 Lisgar St, Ottawa, Ontario, K2P 0C6.

United States

Alcohol And Youth — June 1-2, 1978, Niagara Falls, New York. Information: Father O'Leary (716) 285-1216.

Conference On Alcohol And Youth — June 1-2, 1978, Chicago, Illinois. Information: Alcoholism Treatment Program, Institute of Psychiatry, Northwestern Memorial Hospital, 320 East Huron St, Chicago, IL, 60611.

13th Annual Conference, Association Of Halfway House Alcoholism Programs Of North America Inc — June 4-8, 1978, Minneapolis, Minnesota. Information: Diane Fontaine-Adams, project director, Association Office, 786 East 7th St, St Paul, MN, 55106.

The Committee On Problems Of Drug Dependence 40th Annual Scientific Meeting — June 4-6, 1978, Baltimore, Maryland. Information: Joseph V. Brady, professor of behavioral biology, The Johns Hopkins University School of Medicine, 720 Rutland Ave, Baltimore, MD, 21205.

Primary Care Follow-Up And Evaluation — June 5-6, 1978, Center City, Minnesota. Information: Marilyn Brissett, Box 11, Center City, MN, 55012.

2nd National Youth Workers Conference — June 7-10, 1978, Washington DC. Information: Arlene Rodenbeck, National Youth Alternatives Project, 1346 Connecticut Ave NW, Washington DC, 20036.

Southern Oregon Institute Of Alcohol Studies — June 11-16, 1978, Salem, OR. Information: Ruthanne Lidman, SOIAS, 3355 View Drive South, Salem, OR.

American Medical Association Annual Meeting — June 17-22, 1978, St Louis, Missouri. Information: James H. Sammons, 535 N Dearborn St, Chicago, Illinois. 60610.

27th Session Of The University Of Utah School On Alcoholism And Other Drug Dependencies — June 18-23, 1978, Salt Lake City, Utah. Information: University of Utah School on Alcoholism and Other Drug Dependencies, PO Box 2604, Salt Lake City, Utah, 84110.

5th Regional Addiction Institute North Central Texas Region — June 22-23, 1978, Arlington, TX. Information: Phyllis Holman Weisbard, Institute Coordinator, North Central Texas Council of Governments, PO Drawer C0G Arlington, TX, 76011.

Alcoholism, Drug Abuse and Employee Assistance Programs In The Workplace — June 26-30, 1978, Ithaca, New York. Information: Irene Grant, Cornell University Conference Center, New York State School of Industrial and Labor Relations, PO Box 100, Ithaca, NY, 14853.

Annual Summer Session Of The Center For Alcohol And Addiction Studies — June 19-21, 1978, Anchorage, Alaska. Information: University of Alaska, 3211 Providence Dr, Anchorage Alaska, 99504.

Joint Conference Of The American Association For Automotive Medicine And 7th International Association For Accident And Traffic Medicine — July 10-15, 1978, Ann Arbor, Michigan. Information: AAAM executive-secretary, PO Box 222, Morton Grove, Illinois, 60053.

20th Annual International School Of Alcohol Studies — July 16-21, 1978, Grand Forks, North Dakota. Information: Department of Conferences and Institutes, Division of Continuing Education, Box 8277, University Station, University of North Dakota, Grand Forks, ND, 58202.

13th Annual Teenage Institute On Alcohol And Other Drugs — Aug 6-10, 1978, Granville, Ohio. Information: Elaine Zabor, Teenage Institute Director, Division of Alcoholism, Ohio Department of Health, PO Box 118, Columbus, Ohio, 43216.

1978 Summer Institute On Drug Dependence — Aug 27 — Sept 1, Colorado Springs, Colorado. Information: Summer Institute, PO Box 2172, Colorado Springs, CL, 80901.

Alcohol And Drug Problems Association of North America Annual Meeting — Sept 24-28, 1978, Seattle, Washington. Information: Lynn Buttorff, executive assistant to director, ADPA, Suite 204, 1101 15th St NW, Washington DC, 20005.

American Association For Automotive Medicine — Oct 3-6, 1978, Louisville, Kentucky. Information: AAAM executive-secretary, PO Box 222, Morton Grove, Illinois, 60053.

Association of Labor-Management Administrators and Consultants On Alcoholism Annual Meeting — Oct 4-6, 1978, San Francisco, California. Information: ALMACA, 11800 Sunrise Valley Drive, Suite 410, Reston, Virginia, 22901.

Abroad

8th International Institute On The Prevention And Treatment Of Drug Dependence — June 4-9, 1978, Menton, France. Information: International Council on Alcohol and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

24th International Institute On The Prevention And Treatment Of Drug Dependence — June 25-July 1, 1978, Zurich, Switzerland. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

5th Institute On Drugs, Crime, and Justice In England — July 11-29, 1978, London, Eng. Information: Arnold Trebach, director, Center for the Administration of Justice, The American University, Washington DC, 20016.

32nd International Congress On Alcoholism And Drug Dependence — Sept 3-8, 1978, Warsaw, Poland. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

3rd World Conference Of Therapeutic Communities — Sept 17-22, 1978, Rome, Italy. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

International Symposium On Alcoholism And Drug Dependence — Oct 16-20, 1978, Sao Paulo, Brazil. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

9th International Institute On The Prevention And Treatment Of Drug Dependence — April-May 1979, Manila, Philippines. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

25th International Institute on the Prevention And Treatment of Alcoholism — June, 1979, Tours, France. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

International Conference On Alcoholism And Drug Dependence — September, 1979, Tegucigalpa, Honduras — Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

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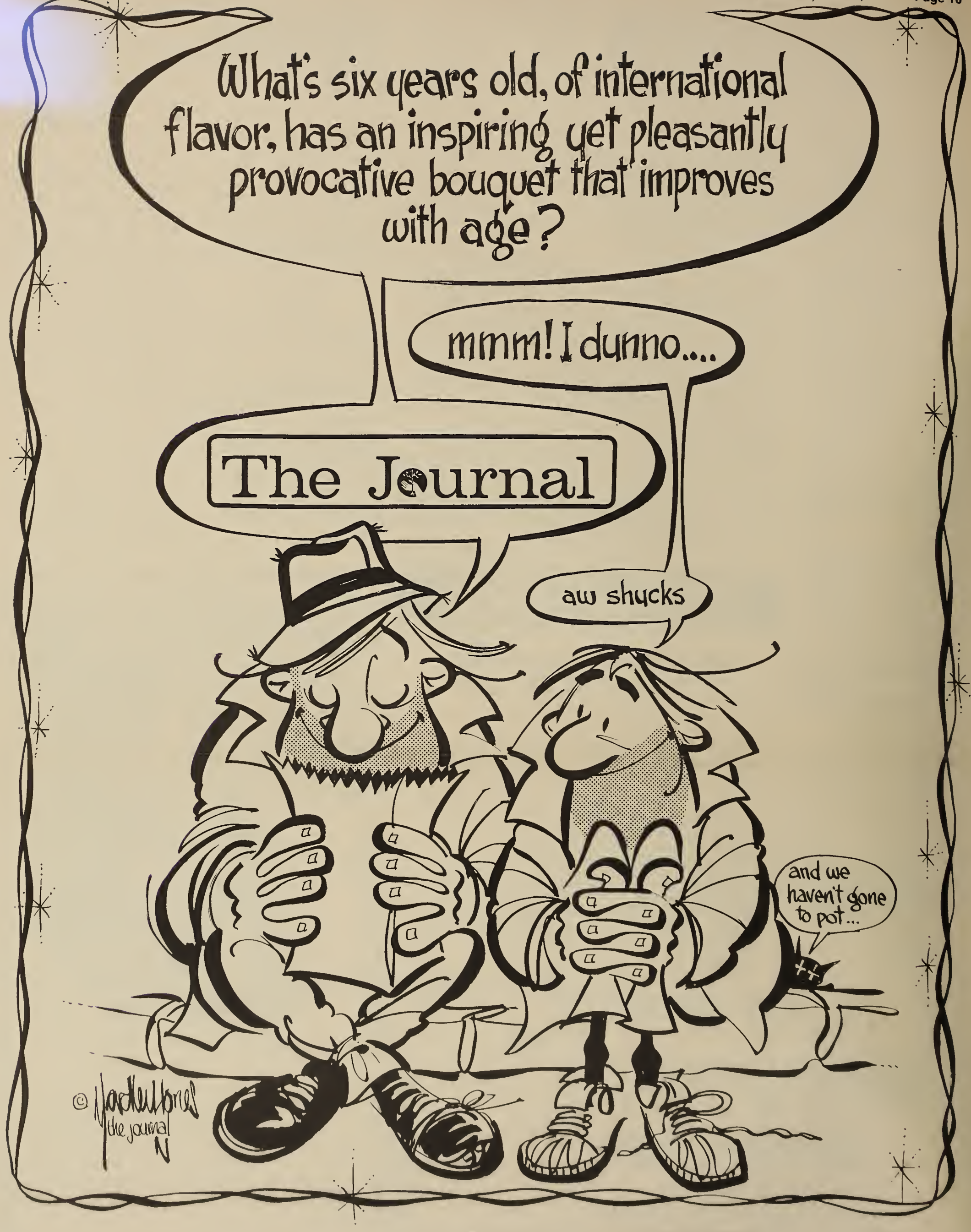
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The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

Probe may open secret drug files

By Bryne Carruthers

OTTAWA — Federal Health and Welfare Minister Monique Begin has launched a special investigation into the circumstances leading up to the complete exemption of the Federal Bureau of Dangerous Drugs File No 14086 (drug users and distributors) from public scrutiny under the Human Rights Act.

The ministerial investigation, which could lead to the opening up of the controversial files to inspection by named individuals, was a direct result of a lengthy investigation by **The Journal**.

The health department file contains information on more than 200,000 known and suspected drug users in Canada, based on police reports, conviction records, medical and pharmacy reports, and even on complaints from disgruntled neighbors.

Many of the persons with drug files have never been convicted of drug crimes.

And the files contain mistakes, federal officials in charge of the files admit — mistakes that the Human Rights Act is supposed to allow Canadians to check for, challenge, and request be corrected.



Monique Begin has launched a special investigation into Canada's secret drug files.

As a result of a special cabinet order approved earlier this year, just before the privacy provisions of the Human Rights Act came into force, Canadians named in the files cannot even find out whether their files exist, let alone whether the information contained in the files is incorrect.

However, while there is strong evidence that the health department and the federal cabinet erred in keeping the drug user files secret in the first place (under privacy provisions of the Human

(See — Health — page 6)

BC law lets gov't start forced therapy

VICTORIA, BC — British Columbia's controversial program for the compulsory treatment of heroin addiction is expected to start January 1, 1979, unless growing opposition interferes with its implementation.

Health Minister Robert McClelland told The Journal in mid-June he expected the Heroin Treatment Act, which authorizes setting up the program, to be passed into law before July.

The Act (Bill 18) was first tabled in the legislature May 29 and Mr McClelland said it would likely take no more than a month for legislative debates, discussions in committee, and final passage.

"What we're going to have is the most humane and probably the most comprehensive program ever tried in North America," said Mr McClelland. "This is not a concentration camp we're setting up; we're not reverting to Nazi Germany."

Critics of the program are not so confident. A Vancouver group, the Ad Hoc Committee on the Compulsory Addiction Treatment Plan, has called for a public inquiry into Bill 18. Spokesman Bruce Clark claimed the government has run a fear campaign.

The province's lawyers have also voiced strong opposition to the plan. A resolution passed unanimously at the BC Bar Association's annual meeting in Penticton charges: "Bill 18 strikes at the fundamental concepts of our society, access to due process of law, and the principles of natural justice."

The lawyers are urging the government to delay implementation of Bill 18 because "sufficient time must be made available for the public, and interested parties, to assess all the ramifications and consequences of the Bill, and make informed representations."

The medical profession in the province originally backed the plan, but it too has joined the opposition forces. Last Spring, following a January presentation by Mr McClelland and Bert Hoskins, chairman of BC's Alcohol and Drug Commission, the board of directors of the British Columbia Medical Association passed a resolution supporting "the program of direction into treatment for narcotic addicts proposed by the government of BC."

Last month the doctors qualified their support.

James Gilmore, communications director of the BCMA, told The Journal the province's doctors support any effective program for dealing with narcotic addiction. However, in their view, Bill 18 deals with a "social and legal problem which has minimal medical implications."

Because of this, the association's drug dependency committee sees the presence of two physicians on the program's assessment panel as irrelevant.

According to Mr McClelland, treatment programs to be used will include the "tried and true methods" of behavior counselling, behavior modification, job and life skill training, and family counselling. Methadone maintenance will not be used.

Latin women take to liquor

By Anne MacLennan

CARACAS — Latin American women may be on their way to drinking as much and as often as North American and European women.

Fewer of them are abstaining and an increasing number are heavy drinkers, Marilynn Katatsky told an international meeting here on alcohol and drug dependence.

Dr Katatsky is regional advisor on alcohol and drug dependence for the Pan American Health Organization of the World Health Organization.

She said the increase in alcohol consumption is particularly evident among the younger, more educated, and middle and upper class women.

"It's the first time we have data which indicate some change may be taking place in the drinking patterns of Latin American women," she said.

She cautioned that no longitudinal data are available and the suggestion of a change is based on drinking differences in different age groups. It was in the 25- to 34-year old age group that drinking was most pronounced.

If the change proves to be real, she said, "certainly, it could be seen in terms of changing roles for women and of their increasing 'liberation'."

The indication came in the first multi-national study of drinking patterns in Latin America. Five cities were surveyed — Sao Paulo, Bogota, San Jose, Caracas, and Santo Domingo.

Although men are still much more likely to drink, and to drink heavily, than women, Dr Katatsky said the study results suggest that increased drinking by both sexes in Latin America "requires more attention."

Like their North American counterparts, Latin Americans favor hard liquor as their first choice with beer in second place. They differ from North Americans in that they drink less frequently and get drunk less often, said Dr Katatsky.

The study was carried out under a grant from the United States National Institute on Alcoholism and Alcohol Abuse.

Jury out on US pot laws

WASHINGTON — A battery of expert scientific opinion on the possible effects of marijuana use is now under scrutiny by three federal judges who will decide eventually on the constitutionality of federal marijuana laws.

The week-long hearing, which was limited to expert testimony, is the result of a suit filed in 1973 by the National Organization for the Reform of Marijuana Laws (NORML).

NORML claims that the present laws are a violation of the rights of privacy, and criminal penalties for private possession of the drug are a cruel and unusual punishment and denial of equal protection of the law.

The hearing was held before Judge Aubrey Robinson, who will now confer with two other judges to decide a final ruling. The losing party, NORML or the US government, has right of direct appeal to the Supreme Court.

Judge Robinson said at the end of the hearing he had been "extremely impressed with the witnesses for both sides. We are fortunate in being able to assemble these kinds of experts for what is an extremely difficult problem."

No decision by the judges is expected before early 1979.

Bureaucratic protectionism appears to be more powerful than right or wrong, writes Bryne Carruthers, commenting on his six-month investigation for The Journal of Canada's still-secret drug use and distributor files. Page 9.

John Shaughnessy travelled to British Columbia in June to investigate that province's controversial new Heroin Treatment Act. On The Back Page, he reports the new legislation in detail. His opinion (page 9) is that BC has "gone too far."

The coffee which gets most North Americans started in the morning may soon have a special attraction for athletes in endurance sports. Page 2.

Officials in Manitoba and The Yukon have expressed grave misgivings about the effect BC's new legislation may have on other provinces. Page 3.

Endurance athletes may find 'super pill' in caffeine

WASHINGTON — Researchers at Ball State University, Indiana, are testing a legal stimulant that could increase significantly the performance of athletes in endurance events.

It is, surprisingly, caffeine administered in controlled doses.

The effects of caffeine on nine trained cyclists over a two-hour ride on laboratory machines "quite frankly amazed us," says John Ivy, PhD, director of the investigation.

Cyclists were given 250 mg of caffeine, equivalent to five cups of coffee, an hour before the ride and another 250 mg during the first 90 minutes of the ride.

The cyclists not only increased their normal output by an average 7.4% but reported they did not feel as though they had done more work.

The more startling performance was by the most highly trained cyclist: his output went up by a phenomenal 25%. "In fact, he went at such a pace he broke the cycle machine," Dr Ivy told **The Journal**.

Dr Ivy and his colleagues are now planning dose response trials because they found some of the riders were given too much caffeine and became jittery and nervous although their performances were not increased or decreased.

If future trials bear out the initial findings, it could have a profound effect on long distance runners and football, soccer, and rugby players who are always looking for an athletic "super pill." Many of them secretly take stimulants.

Dr Ivy points out that caffeine's stimulant effect has been known for decades. Too much caffeine, generally via coffee or cola drinks, can lead to a jittery condition, sometimes with nausea, but it is metabolized quickly.

Caffeine has been used in the past in short endurance events but no significant increase in performance was found.

Dr Ivy's findings with caffeine came about more by accident than design. The test was to see if a glucose polymer could help in performance: caffeine was used as one of the variables. Glucose did not increase performance but caffeine did.

Dr Ivy says: "The workload of the cyclists did start to drop off after 90 minutes, but not that dramatically. We think the caffeine was still working but the riders suffered a reduction in muscle glycogen, which we think is the key to endurance work and that caused a reduction in workload."

Muscle glycogen levels can be replaced within three days on a normal diet or within 24 hours on a high glucose or carbohydrate diet. A three-day high carbohydrate diet can actually double the amount of carbohydrate in the muscle called glycogenloading.

Dr Ivy believes glycogenloading and then use of caffeine by a trained athlete "very defintely" would increase his performance.

Dr Ivy has also done a personal trial on the machines. Without using caffeine "I tried to keep up the pace to the most highly trained cyclist. I lasted I think about five or 10 minutes."

BC lawyers endorse cannabis decriminalization

By John Shaughnessy

PENTICTON — British Columbia lawyers have officially thrown their support behind the move to decriminalize marijuana.

At its annual meeting here, the BC branch of the Canadian Bar Association passed a resolution endorsing "the decriminalization of simple possession and cultivation of cannabis for an adult's use and the non-profit transfer of small amounts between adult users, specifically that cannabis be removed from the Narcotic Control Act and be placed on the Food and Drug Act, Schedule G."

The decriminalization resolution earlier received near unanimous support from the province's criminal lawyers in Vancouver, Victoria, and New Westminster as well as from the BC Bar Association's provincial council.

But, proponents of the resolution ran into unexpected opposition here. As originally presented by Peter Richie, chairman of the association's Vancouver criminal justice section, the resolution endorsed the decriminalization of possession and cultivation for one's own use as well as non-profit transfers between users.

The final version, specifying use and cultivation by, and transfers between adults, followed a debate over the potential immunity of adults who made non-profit transfers of cannabis to children if cannabis was in fact decriminalized in the manner originally suggested.

Another faction led by Branch executive member, Robert Dick, felt possession of marijuana should remain an offence. Mr Dick wanted Canadian legislation to follow the American model, in which the person found in possession of marijuana receives a citation and a fine, but has no criminal record and is not arrested.

He said this approach would eliminate the "horrendous penalties now being imposed on young marijuana users" without encouraging more widespread marijuana smoking and eventually total legalization and open commercial sale of the drug.

Ted Seifred, one of the architects of the original motion and a director of NORML Canada, (National Organization for the Reform of Marijuana Laws) convinced the association that Mr Dick's proposal was not workable in Canada.

He said the concept of a citation was unknown in Canadian law, and that under the Canadian constitution the federal government could not make cannabis possession a civil offence.



Beer and cider are sold now in grocery stores in Quebec. A further move by the provincial government allows sales on Sundays.

...But have some more wine

MONTREAL — With no announcement of any improvement in facilities for the treatment of alcoholism — not to mention the dangers of drinking and driving — beer and cider sales on Sunday are now permitted in Quebec. If shopping at the corner store, it will also be possible in September to add to the Sunday shopping list wines made or bottled in Quebec. (The Journal, April).

***Depanneurs* — small grocery stores with three or fewer employees — may now sell beer and cider to customers from 8 am to 11 pm on Sundays. It is expected that the change will be good for business for some 7,500 corner stores; that many of them that could not afford to stay open seven days per week may now do so.**

Provincial government scolds

Quebeckers drinking too much...

By Dorothy Trainor

MONTREAL — Two days after the Sunday sale of beer and cider was authorized in some 7,500 corner stores in Quebec, the Partie Quebecois government has tabled its white paper on culture chiding Quebeckers for drinking too much.

On the subject of alcoholism and drug abuse, the white paper also states: "The government believes it necessary to take vigorous action in the field of advertising and by applying regulations more strictly and by countering with its own publicity."

With no explanation of this apparent contradiction in aims, the white paper goes on to scold "Canada's champion smokers" and berate Quebeckers for abusing drugs and medications. It promises an educational campaign in the schools designed to produce within the next 10 years "the first generation of non-smokers." This will be coupled, the paper states, with increased tobacco taxes to pay for health services required because of smoking. This document also promises services for the early detection of drug and alcohol problems, and that treatment will be established in local community service centres.

The Corporation of Physicians of Quebec is called upon "to ensure that its members are informed with a view to impressing on them the need to decrease the alarming consumption of drugs affecting the central nervous system, and especially of tranquillizers and anti-depressants."

Serious increases in wine and spirit consumption, the paper states "show without a shadow of a doubt that a growing number of people are having serious trouble in adapting to their milieu." A nation's health is measured by "the ability of its people to provide themselves with an adequate human environment that is both a condition and a reflection of their culture."

Airline smoke ban shelved

WASHINGTON — Proposals for tighter control of smoking aboard American commercial airliners has been shelved for the time being in a surprise move by the Civil Aeronautics Board.

The board had been expected to issue a ban on pipe and cigar smoking on all commerical flights, and issue for public reaction a proposal to ban all cigarette smoking.

Instead, in a vote, the board members split evenly over the proposals, and with no majority decisions any further action has been deferred.

Howell's guide to 'super neat' summer meetings

By Wayne Howell



This is the season of the year when the *Coming Events* section of **The Journal** blossoms forth with notices of all manner of conferences, symposia, study sessions, and short academic courses slated to take place during the dog days of summer. Some of the more interestiug ones have spilled over into my column space:

Seminar on Cannabis Control Techniques — July 1-4, 1978, The Pentagon, Washington DC. The principles of creative poisoning. Lessons from 'Nam and how they can be applied to Mexico. Toxic residues and how to get the most out of them. Focus on the future: the practical use of low-yield nuclear devices to defoliate suspect acreage south of the Rio Grande. Information: Colonel T. Strangelove, Washington, DC, 70001.

Political Perspectives on Cannabis Legislation — August 3-7, 1978, Aspen Colorado. A course especially designed for persons holding, or running for, political office. The use of ambiguity on the campaign trail. Fence sitting. Advanced fence sitting. Long term fence straddling. Legislation avoidance and legislation stalling. Special guest lecturer: Monique Begin, Canadian Minister of Health and Welfare. Information: Inertia Institute, Boston, Mass, 56007.

Social Science Jargon Summer Course — July 8-12, 1978, Toronto, Canada. A must for the ambitious paper writer or neophyte conference speaker who wishes to actualize latent abilities for obfuscation through the modality of the small group interface animated by neologizers who will paradigmize efficacious methodologies: learn how to sound impressive in work shops conducted by people who know how and will show you. Information: J. A. Bonmot, Buzz-Word Bureau, Chicago, Ill, 56731.

First Annual Super Conference on Cocaine — September 2-5, New York, New York. Especially designed for magazine feature writers who want to warn the public about the dangers of cocaine abuse. Visiting pimps will provide interesting (and racy) background on their lifestyles. Special guest lecturer Robert Sabbag, author of the smash best seller *Snow Blind*. Guest rock stars. Interviews with jet setters. Great Copy! All the glamour and excitement of cocaine and why dwelling on this ad nauseum is a public service.

Special Academic Symposium on the new 'light' pathologies caused by the new 'light' beers — August 9-12, 1978, Milwaukee, Wisconsin. Papers on: 'teensy-weensy' fatty infiltration of the liver; 'light 'n easy' esophageal varices; 'just a touch' brain atrophy; and 'crypto-Korsakoff's syndrome'. Information: Light Anatomical Pathology Department, Madison, Wis, 34567.

First International Conference to Censure the ARF so-called 'fact sheet' on Marijuana — September 1-5, 1978, London, England. A must for all marijuana nit-pickers. Special guest lecturer Dr J. T. Ungerleider will explain why the perfidious fact sheet is a scandal because it "reads like the informed consent forms that we use in our marijuana research project where almost every adverse reaction to marijuana that has ever been recorded has to be described to the patient". Dr David E. Smith will lecture on why it is improper for the ARF to exhibit before the impressionable lay public a so-called 'fact sheet' that contains the facts you have to give people before the law allows you to use them as guinea pigs. Information: The Mellow Institute, Los Angeles, California, 78900.

Fourth International Conference on Neat Spots to Hold an International Conference — Seychelle Islands, August 4-10, 1978. A must for conference planners: winter neat spots; summer neat spots; neat spots for those troublesome in-between seasons when you can't count on the weather. Information: Neat Spots Institute, Geneva, Switzerland.

(Wayne Howell is an Ottawa physician and freelance writer.)

ARF study proposes community approach to alcoholism

TORONTO — A new treatment framework for problem drinkers and alcoholics has been recommended for Ontario.

The proposal would facilitate a systematic approach to dealing with the growing population of people afflicted with alcohol problems in the province, according to Joan Marshman, chairman of the Task Force on Treatment Services for Alcoholics.

After about 18 months of study, the task force has presented 51 recommendations for consideration by the executive committee of the Addiction Research Foundation of Ontario, and circulated the report to the Ontario government. The government would be responsible, ultimately, for overseeing implementation of the recommendations, if approved.

Dr Marshman, head, Pharmaceutical Sciences, Clinical Institute, research division of the ARF told **The Journal** two of the significant findings of the study were:

- present treatment services in Ontario deal generally with the "deteriorated alcoholic" while the task force is promoting early intervention; and
- community based treatment is seen as both cost-efficient, more accessible to residents, and "better than anything imposed from outside."

For the study, Ontario was divided into 11 regions, and each region's treatment resources were investigated. The task force report says: "Alcoholics treatment resources showed marked variation along many dimensions, including their philosophical orientation, goals of treatment, duration of treatment, treatment methods, the extent to which health care professionals are involved in the treatment process, the nature of their association with a hospital, and the provision (or absence) of a residential component.

The report says also: "There is undoubtedly a need in the province for more effective organization of chemical dependence treatment resources than currently exists. Ideally, the effective articulation of such resources would evolve through 'grass roots' effort in the community; indeed such effort is vital to any developmental process, and without it no super-imposed framework is likely to be effective."

Dr Marshman said any changes in treatment in Ontario have to develop with community support. "We hope that the principles we've put forward will serve as a basis for the development of local thinking in systematic way, so that perhaps some of the aspects of the report could actually be implemented in individual regions with the support of the community and the district health councils and so on.

"(The report) won't be an all or nothing."

Manitoba fears an influx of addicts from BC

By Manfred Jager

WINNIPEG — Sources in the Manitoba health field have warned that compulsory treatment of narcotics addicts in British Columbia will swamp major prairie cities with addicts from the west coast.

Under the legislation, addicts can be directed into institutional withdrawal treatment for up to six months.

The Winnipeg sources — without exception asking not to be identified because of the potential controversy of the subject — expressed a number of fears:

- That the BC government is using the lever of compulsory treatment more as a political tool to deal with public concern over the proliferation of heroin addiction on the west coast, hoping not so much to treat and cure addicts as to get rid of them through escape to other parts of Canada.
- That addicts will indeed leave the province, not in a trickle but in droves.
- That as they leave, the addicts will be taking with them their entire subculture with heroin distribution systems and contact networks.
- That major cities such as Edmonton, and particularly Winnipeg because of its size and location, will attract fragments of the BC heroin subculture, which will then grow in their new habitats.
- That addicts, needing their social environment, friends, dealers, and supply lines, will be firmly entrenched in their new locations within a few months, bringing with them increased supplies of heroin.
- That as heroin supplies in this part of the continent increase, so will the number of new addicts from among the younger generation in the local population.
- As the number of heroin addicts in the city swells, the crime rate in turn would increase by leaps and bounds because addicts must steal and rob to support their habits on a daily basis.

"It's an expensive way of not dealing with the problem," one health agency official said. "It means you're passing the buck to the other provinces and hoping to let them deal with the situation you found you can't get a handle on."

Compulsory treatment has never worked anywhere, the source, who has worked in the narcotics addiction field for some time, said.

"Sure, you can dry a heroin addict out, but he or she must first want to quit. Otherwise they'll simply go back on the stuff as soon as they are out of your control.

"We have seen this with junkies in the penitentiaries. They're in there not for a few months but for years, and many of them get dried out as far as heroin is concerned. Yet within hours of being on the outside, they've been shown to be back on the stuff.

"The rate of recidivism in heroin addiction is incredibly high, and there's a good reason for it. The reason is that heroin addicts actually want to use the drug and like using it because it helps them deal with their severe social and cultural problems."

Another source said the legislation "will be of major concern to all western provinces and beyond that to the entire country. I for one believe you can deal with massive addiction problems through compulsory treatment. All you have to do is make sure they are all caught and treated wherever they show up."

The source predicted that the BC legislation will trigger similar acts in virtually all other Canadian provinces as they become subject to the influx of addicts from the west coast.

Health sources say as many as 200 heroin addicts may be living in Winnipeg now, but senior Winnipeg police officers were evasive when asked to confirm or deny the estimate.

Yukon echoes Manitoba's fears

WHITEHORSE — Members of the RCMP drug squad here are concerned that passage of British Columbia's compulsory drug treatment legislation will drive heroin addicts north to the Yukon.

Corp Dennis Flewelling, former head of the local RCMP drug squad, said the legislation will result in addicts "migrating to all points of the compass" and that includes the Yukon.

"It seems to me that you have a great deal of difficulty curing someone of heroin addiction and if someone knows that when he's caught, he will be forced to take this program, he will take every step to ensure he is not caught."

Corp Flewelling, formerly senior member of the four-man drug squad, went on to say there are "no known addicts" in Whitehorse because the capital city is too far from the major centres of supply of heroin and other hard drugs.

But compulsory drug treatment in BC will be an incentive to start trafficking in the Yukon.

Even "10 addicts in the Yukon as a result of this legislation would be a lot of addicts for this little territory," said Corp Flewelling. The Yukon population is about 23,000 people.

Women's resource kit for health educators

TORONTO — A resource kit on women and addictions has been prepared by a group of Ontario women to aid in the educating of health care professionals.

The kit, *Women and Addictions: Alcohol and Minor Tranquillizers*, was produced by the Caucus on Women and Alcohol and Drugs. The caucus stemmed from the Ontario consultation on women and addictions in Ottawa in 1975 — the first meeting in Canada to focus directly on special problems of addicted women.

The kit is aimed at health care schools in the province and the caucus hopes it will be used by educators to alert students to social expectations of women and how their role pressures affect female addicts in particular. It will also be used in a series of workshops for addiction workers in the province.

The introduction says: "If effective treatment is to be provided to women, health care professionals must support an integrated understanding and articulation of the social and personal needs of women. They must also have a critical grasp of their own role in relation to the female addict."

Ruth Copperstock, a member of the caucus and a scientist at the Addiction Research Foundation, says response has been good to tests of the kit in various selected schools of nursing, social work, medicine, and pharmacology.

The kit includes a video cassette depicting the isolation of women working at home and their use of alcohol and minor tranquillizers to cope; a flip chart; guidelines to the chart; and three research papers.

It was funded by Non-Medical Use of Drugs Director, Health and Welfare Canada. Information is available from Jessica Hill, acting regional director, Non-MUDD, 102 Bloor St. W., Toronto M5S 1M8, Canada.

Jan DuPlain resigns NCA

WASHINGTON — Jan DuPlain, executive director of the Office on Women of the United States National Council on Alcoholism, has resigned.

Ms DuPlain, who has held the position since the office was established in March, 1976, is leaving to move to California. She says she will continue her involvement in women and alcohol issues.

No new director has been appointed as yet. However, Ms DuPlain told **The Journal** that NCA will be reviewing applications for the post "through September 1 of this year."

In the meantime, she said, the office would be moved to NCA's head office in New York City and continue under the supervision of the director of community services who will assign a staff person as women's coordinator.

Reviewing her two years in office, she said: "The field was ripe and the time was right for establishment of the office and the support of both women and men has made it successful."

She said the women and alcohol movement is "coming into its finest hours. Looking back at where we were and where we've come is phenomenal."

Yukon pipeline boom attracts drugs

WHITEHORSE — A dramatic shift in drug use to cocaine and LSD in Whitehorse has authorities worried that the drug situation in the Yukon may get out of control.

In a territory where marijuana possession made up to 97% of all drug seizures in 1976, the influx of cocaine and LSD traffickers is seen as an indication of what can be expected with the boom of the Alaska Highway pipeline.

In 1976, LSD and cocaine made up 1.5% of all drug possessions. In 1977, those figures increased to 8% and to 12% respectively.

In 1977 alone, 1,028 capsules of LSD were seized, compared to none the previous ear.

Similarly, while only 0.5 grams of cocaine were found in 1976, 9.8 gms were seized in 1977.

Marijuana possessions, on the other hand, are decreasing — from 97% in 1976 to 80% of total seizures in 1977.

The trend to hard drugs appears to be growing, with more than 325 tabs of acid seized already in the Yukon in the period ending May 31.

RCMP Corp Dennis Flewelling, former head of the Whitehorse drug squad, is afraid the shift from soft to hard drugs is a result of publicity surrounding the proposed Alaska Highway gas pipeline which will pass through the Yukon.

The phenomenon is also regarded as an indication of an impending repeat of the serious drug problems in Alaska that accompanied the building there of the Trans-Alaska oil pipeline.

Authorities are concerned about the type of people drawn by the big money of a pipeline boom: card sharks, prostitutes, and one-shot drug pedlars.

"Those people are already showing up here," the corporal said.

He fears that when construction on the pipeline does begin in two years "the word is going to get around and heroin traffickers will begin to show up in the Yukon for the first time.

"Every time there is a guy making money, there's someone behind him taking it."

RCMP authorities have requested two additional drug squad members to cope with the pipeline boom.

And they are well aware of the Alaska situation where hard drugs alone increased by more than 200% during the Trans-Alaska pipeline construction period.

J778

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Alcoholic workers regress rapidly in retirement

By Betty Lou Lee

TORONTO — Alcoholic employees who do well in their company's constructive coercion program may return to their former drinking habits when faced with the stress of retirement, the Dominion Foundries and Steel Company in Hamilton is finding.

It was one of the first companies to introduce such a program on a comprehensive scale 14 years ago, and has had positive results in about 80% of cases.

"The grief of it is, when they retire the results are awful," Robert H. Martin, company medical director told the annual meeting of the Ontario Medical Association here.

"We have had something like two burned to death in bed through smoking when they were drunk. We had three of them die from cirrhosis of the liver. One is a pure vegetable now because he has so much brain damage he hardly knows he exists. That sort of thing goes on. Once the clamps are off, they regress very rapidly."

Dr Martin was reporting on results with the 347 employees who've taken part in the Dofasco Employee Assistance Program since it was instituted. The company has about 11,000 workers, and it has a sophisticated records and reporting system not only to spot where drinking may be affecting job performance, but to document it for the worker. He runs the risk of losing his job if he doesn't participate in the program, which includes one month at a special unit of Chedoke Hospital and 14 months of follow-up.

Dr Martin said in an interview that unless people are well prepared for retirement, it can create the stress that triggers a return to their old drinking habits, and they no longer have the threat of job loss hanging over their heads.

Dofasco is working on a retirement preparation program, "not just for the alcoholics, but for all employees. It should start at about age 35 or 40, but it's hard to get people interested at that age." In the interim, his department is trying to work with the alcoholics who are approaching retirement age.

"You are not dealing with a situation where you put a man through rehabilitation, he has a good result, he goes his 14 months under the program and everything is fine from there on in," Dr Martin said.

"You have bought yourself a problem for the rest of the man's working life. You've got a ball of wax in these 347 people who need constant looking after so they can cope with their environment, because if you introduce a crisis in the lives of any one of these people, guess what they do? Well, you're right. It does not take much of a crisis for some of them. But that is what you buy."

Among its 347 cases, Dofasco considers 60% had good results: the man may relapse once or twice a year, but he is cooperative, well-motivated, and trying to kick his habit. Another 23% had fair results: not always abstinent and cooperative, and "bucking us a little".

Dr Martin also said that the typical medical profile of workers in the program often didn't change after they were rehabilitated and off alcohol because their health had already been so badly damaged their absenteeism stayed up. They examined illness, absenteeism, accidents on and off the job, and work performance reports a year before and a year after the program for everyone who entered it over one five-year period.

"We found an amazing thing, that 54% of those people admitted into the program had a typical medical file . . . the disturbing thing about it is that these people got into this symptom-complex and got well down, even though you rehabilitated them and got them off alcohol."

They would have been off work a couple of times with gastritis, then later would be diagnosed as having a gastric ulcer. A bleed would follow, then a gastrectomy, then liver disease. "When you see a history like this, you can bet your boots that half the time you are going to be right if you say it is alcoholism."

Ontario planning broad changes in liquor laws

TORONTO — The Ontario government hopes to make sweeping changes in the province's liquor laws.

Legislation, to be introduced in the fall would raise the minimum drinking age from 18 to 19, would crack down on drinking drivers, and would define a new category of "near drunks."

The new legislation, if passed, would also liberalize drinking laws in some areas.

Larry Grossman, consumer and commercial affairs minister, said the proposed changes are an attempt to achieve "a balanced approach which provides the progressive measures the public wants with sufficient safeguards to prevent abuse."

Under the proposed legislation:

- The legal drinking age would be raised from 18 to 19.
- Immediate, 24-hour licence suspensions could be imposed on drivers found to be near the legal blood alcohol limit. Police cars would be equipped with portable alcohol measuring devices, and the police would hand out on-the-spot suspensions to motorists with a blood alcohol level of more than 0.05%. A driver with a blood alcohol count of 0.08% is liable to conviction under the Criminal Code of Canada.
- Enforcement of the drinking age would be tougher. The maximum fine would be increased from $2,000 to $10,000 for drinking under age and for serving alcoholic beverages to those under age. The minimum fine would be $500.
- The current three-month suspension for drivers convicted a third time of drinking and driving would be replaced with a three-year licence suspension.

On the liberal side, the legislation would:

- Permit people in Ontario to order a drink on Sunday without having to order a meal, as is currently the case.
- Allow licensed premises and Liquor Control Board of Ontario outlets to remain open on election days.
- Free airlines from opening and closing time restrictions on alcohol consumption.

Mr Grossman said he hoped the legislation would help end the "senseless slaughter" of innocent people on the highways by those who are irresponsible enough to combine drinking and driving.

0.05% a new wrinkle

TORONTO — A 150-pound man, after drinking two 12-ounce bottles of beer in less than an hour will register 0.058% on a breath test, according to Barbara Spencer, public relations officer for the Addiction Research Foundtion of Ontario.

Legislation being considered by the Ontario government would give police the power to confiscate a driver's car keys, and/or suspend his licence for 24 hours if the driver's blood alcohol level exceeded 0.05%.

After four bottles of beer the 150-pound man would reach a blood alcohol level of 0.08% — the level for legal impairment. If he drank six bottles of beer he would reach a level of 0.11%, and would return to a 0.05% level four hours later.

Tobacco company pleads case for ads

LONDON — A major manufacturer of tobacco products here, Carreras Rothmans (UK) Ltd., has revealed for the first time the industry is growing alarmed by the progress of the anti-smoking lobby.

Although cleverly avoiding identification of its adversary (the Royal College of Physicians pressure group ASH, Action on Smoking and Health) the company's marketing director Rex van Rossum, says: "It is a matter of concern both to the tobacco industry and indeed to the whole advertising industry that there have been so few voices raised against the well-organized clamor for a complete ban on cigarette advertising."

Writing in the advertising journal *Campaign*, he adds: "Any ban on one of the major factors in free competition must be taken extremely seriously by the marketing and advertising world because if it once starts, where will it end — spirits, beer, motor cars, butter, coffee, sugar, sweets, toothpaste, even apples?"

Mr van Rossum argues that contrary to what critics of tobacco promotion claim, cigarette advertising does not increase consumption, but merely reflects the efforts by individual companies to increase their share of the market.

"Whatever the effect of advertising on consumption in other consumer goods markets, in the case of cigarettes there is a nil correlation between total advertising and total consumption," he says.

Comparison between Italy, where advertising was banned in 1963, and Britain (where only television cigarette advertising is banned) showed that consumption in the two countries had increased by 15% and 14% respectively (Italy 15 and GB 14) in the period 1965 to 1970.

Further comparison of attitudes of Italian and British young people (aged 15 to 25 years as reviewed in the McCann-Erickson pan-European Youth Study) supported the suggestion that advertising had a minimal effect, Mr van Rossum said. Although the Italian young people had grown up during a period of no cigarette advertising, it was found:

	ITALY	UK
Never smoked:	25%	24%
Tried, but did not like it:	18%	26%
Total non smokers:	43%	50%
Tried and smoke occasionally:	22%	13%
Smoke regularly:	32%	33%
Total smokers:	54%	46%

Thus, Italy had more trialists and more young smokers than the UK.

The author concludes that if the anti-smoking lobby succeeds in getting the advertising of cigarettes banned it will have the effect of "freezing" the market share situation, thus working in favor of monopoly (Imperial Tobacco currently holds 60% of the UK market).

"The poor old consumer would end up having less choice and paying more," Mr van Rossum says. But (because level of consumption would be maintained) nothing would be achieved for the cause of "the anti-smoking brigade."

1978 Drug Regulation Reform Act

Pharmacists ready to fight

MONTREAL — Over-regulating professional pharmacists will not solve any problems relating to mispreseribing of drugs, according to Philip Sacks, president of the American Pharmaeeutieal Association.

Mr Sacks, in his address to the APhA annual meeting here, left no doubt that APhA will resist any attempt by the United States Congress to enact regulation changes that would give government unprecedented and "unwarranted control" over the profession. His remarks were targeted at the pending 1978 Drug Regulation Reform Act. He reserved his sharpest criticism for what he termed the major threat in the bill — a proposed grant of authority to the US Food and Drug Administration and the department of health, education and welfare.

"If enaeted in its present form, the bill would overturn the entire history of drug regulation and, for the first time, give the secretary of HEW and FDA sweeping control over drug prescribing, distribution, and use. The bill would overturn the profession's hard earned legal victory in the methadone case."

(Between 1973 and 1976, the FDA tried to restrict methadone use to approved hospitals. The APhA successfully countered the proposal on the grounds that methadone is a legal drug which is not used in addiction control only.)

"As this bill is now drafted, the HEW secretary could dictate what physicians could prescribe and what pharmacists could and could not dispense . . . the FDA could restrict the distribution and use of any drug in any way the agency sees fit. The public interest is not served by destroying any profession and the professional judgement of its practitioners in the name of regulation."

The bill as now drafted would also require price posting of drug products, but Mr Sacks pointed out that experience in the US has indicated patients ignore posted prices.

Alcoholic women harder to help

AUCKLAND, NZ — Alcoholism among women is "one of the undiscovered tragedies of the world," according to the world leader of the Salvation Army, General Arnold Brown.

Female alcoholics are both harder to help and harder to recognize than male alcoholics, he said during a visit to the army's sanitorium for alcoholics on Rotoroa Island, offshore from Auckland.

"Women alcoholics are the product of affluence, or near affluence. They have all they need, they have time on their hands, and lack of involvement in our community."

Counselling and supportive help is not enough for the woman with a drinking problem, he said. She should be introduced to a program providing medical and psychiatric help.

General Brown, who was born in England but brought up in Canada, said a Toronto experiment with classified advertisements offering counselling for women with drink problems brought 441 telephone calls in six weeks, and also resulted in 140 face-to-face interviews.

"Some of these women we could help, and the program is spreading," he said.



General Arnold Brown

Hong Kong aghast at new problem

By Lachlan MacQuarrie

HONG KONG — There is increasing evidence that alcohol abuse is a more serious problem in Hong Kong than has ever been considered possible.

Alcohol-related problems have never received much attention here. It has been a long standing and widely held belief that the Chinese, though they have for centuries consumed alcohol in various forms, do not abuse alcohol and seldom become alcoholics.

In Hong Kong, moreover, there has been an understandable preoccupation with one of the world's most serious heroin addiction problems. Partly as a result, little attention has been paid to the dangers or potential dangers of alcohol.

But this situation may be changing. The Hong Kong community, although 98% Chinese, has been subject to both Chinese and Western influences, including traditional patterns of beverage alcohol consumption from both cultures. As a result, Hong Kong has developed high consumption rates of Western beverages, especially brandies and whiskies.

For example, it is the world's largest per capita consumer of cognac, and the fifth largest overall in absolute volume terms, importing 400,000 cases of cognac per year. This works out to about one bottle of cognac alone for every man, woman, and child in the community.

And while the consumption of Western type beverages has continued to rise, the use of Chinese beverages, mainly wine drunk with meals, has remained at a steady level.

S. Y. Woo, who lectures on drug abuse at the Hong Kong Polytechnic School of Social Work, believes alcohol abuse is becoming more serious. In a paper presented to a Hong Kong Council of Social Service Seminar on Drug Abuse, he recommended it become the subject of careful research and analysis.

"In spite of the large amount of alcohol consumed locally, there has been no effort to look into the personal and social effects of alcohol consumption.".

Mr Woo recalled a study by the Society for the Aid and Rehabilitation of Drug Addicts, the largest voluntary heroin and opium addiction treatment program in Hong Kong. It suggested "44% of patients used alcohol prior to narcotic addiction and that many ex-addicts consume alcohol in significant quantities".

And it is not only ex-addicts who are involved. Mr Woo referred to recent reports from the psychiatry department of Hong Kong University. They warn that "alcoholism could become the biggest physically and mentally disabling disease in Hong Kong".

These reports, said Mr Woo, indicate alcoholism is on the increase in Hong Kong but that there is no way to ascertain exactly how many alcoholics there are because of a lack of research. Another difficulty is that very often in Hong Kong neither the alcoholic himself nor the professional to whom he goes for treatment will recognize the disease. Often alcoholics may be admitted to hospital for schizophrenia or other mental disorders or disguised in the files of social work agencies under "marital problems".

Mr Woo said action must be taken to explore the problem and to meet deficiencies in services to assist and treat alcoholics. "As our efforts to control heroin continue to become more effective", he asked, "will alcohol step in and fill the bill?"



Woo Sik Yang

Chalmers vows '100% attack' on alcohol

By John Carroll

FREDERICTON — A 5% tax on alcohol and a 100% attack on alcoholism are the objectives of Everett Chalmers, chairman-designate of the New Brunswick Alcohol and Drug Dependency Commission.

Speaking to the Legislature in May, Dr Chalmers vowed he would press the government hard for funds to run the Commission's program when it commences. Dr Chalmers holds a cabinet post as Minister without Portfolio with responsibility for the ADDC.

Dr Chalmers said that come budget time next year he would ask "for a portion of the revenue received by the government through the increase in the price of alcoholic beverages."

He is on record as saying that $4.5 million to $5 million would be an advisable budget to give the Commission a sound start. In the 1972 report of a study commission he chaired, a key proposal was the imposition of a special 5% tax on alcohol to fund the proposed commission.

At present, the fledgling Commission has a budget of $1.9 million, which Dr Chalmers considers inadequate.

Gross sales of the New Brunswick Liquor Corporation for the year ended March 31, 1977, were $99,657,797, with a net profit of $33,080,211. This was an increase of 2.9% over fiscal 1975/76.

Outlining some of the costs, social and monetary, of alcoholism, Dr Chalmers told the Legislature that based on statistics gathered by the department of health, he estimated more than 1,000 alcoholics spent 7,580 days in general hospitals at an expense of $603,000. In addition, 454 were treated at provincial mental hospitals in Campbellton and Saint John at a cost of $290,000.

He said 1972 statistics that indicated one of every five alcoholics is a female are outdated, and a more accurate tally would be one in three. Dr Chalmers, who has come under fire for saying women who wish to raise children ought to stay in the home, (**The Journal,** June) said the typical female alcoholic starts drinking between 30 and 33 years of age, and by age 40 she has had her first hospitalization for alcohol-caused complications. He charged that society had failed to recognize the problem of the female alcoholic "and she usually ends up drinking at home, unnoticed."

Provincial statistics show 95.6% of patients treated in provincial detoxification and rehabilitation units are male. There are 92 beds in detoxification units, of which only six are alloted to females.

Dr Chalmers asserted that misuse of alcohol is a social problem of major significance. He spoke of "the age of escape" and said: "We drink to be sociable, to be chic, to relax, to gain courage, to add romance to our meals, and too often for many of us to run from depression and fear and our own inadequancies."

He said too much emphasis is placed on non-alcohol drug usage because those drugs "are somehow frightening and foreign", but little attention is paid to alcohol and its victims. Parents worry over their children becoming dependent on drugs, yet pay scant attention to the possibility of them becoming alcoholics.

NB women challenge Chalmers' objectivity

SAINT JOHN — The New Brunswick Advisory Council on the Status of Women has launched a direct challenge to provincial Alcohol and Drug Dependency Commission Chairman-designate Everett Chalmers by publicly stating it will insist on 50% representation on the ADDC.

Dr Chalmers stirred the ire of many New Brunswickers, especially women, in April, by asserting that women's liberation and juvenile delinquency were linked.

Following sessions here in mid-May, the Advisory Council announced it "is very distressed by the attitude toward women implicit in Dr Chalmers' remarks and has grave doubts as to his competence to deal objectively and compassionately with the problem of women alcoholics and drug addicts in New Brunswick."

In its news release, the Council stated: "Currently, treatment programs and facilities for women alcoholics and drug addicts are almost non-existent ... as a result we find it necessary to insist at least 50% of the appointed members of the NB Commission ... be women who are knowledgeable in this area.

"In addition, we feel very strongly that a professionally-qualified woman coordinator be hired by the Commission to oversee the implementation of treatment programs and services for women alcoholics and drug addicts. This coordinator will keep the NB Advisory Council informed as to the activities and programs of the commission."

US Forces drug abuse hearing

Army problem 'serious not epidemic'

WASHINGTON — An internal United States Army survey has found an estimated 31% of enlisted men and women use marijuana and 7% use heroin, LSD, or amphetmaines.

The figures were given by Brig Gen John H. Johns to the House of Representatives committee on narcotics abuse and control which is holding lengthy hearings into the drug abuse problem in the US Armed Services (**The Journal,** June).

Gen Johns said the random survey showed 18.6% of the respondents said they smoked marijuana occasionally and 12.6% said they smoked it frequently. This would indicate some 209,000 personnel use the drug.

Some 5.7% of the respondents said they use hard drugs occasionally and 1.6% said they used them frequently. This would mean some 49,000 personnel are using hard drugs.

Gen Johns said: "The Army views its drug abuse problem as serious but not of epidemic proportions.

"The abuse does have some degree of adverse impact on combat readiness but it is difficult, if not impossible, to establish a definitive causal relationship that can be quantified."

He added the survey indicated hard drug use has dropped but marijuana use has remained steady. The figures are higher than estimates of drug abuse among civilians, but the majority of army personnel are in the 18- to 25-year-old age bracket, the group which used drugs most.

Representative Glenn English attacked the survey. He questioned whether many soldiers would jeopardize a career by admitting to an unlawful act, and criticized the people answering being allowed to determine whether their use was frequent or occasional.

Air Force Lt Gen B. L. Davis told the committee use of hard drugs by enlisted airmen is on the decline while marijuana use is at a steady level.

Gen Davis added: "Drug abuse remains a serious personnel problem, particularly among 18- to 25-year-old personnel, and it merits continued emphasis."

Congress is under pressure by President Jimmy Carter's administration to allow a return to random uninalysis as a major means to control drug use in the forces.

Cocaine infiltrating Europe via more new border points

CARACAS — More and more cocaine is entering Europe, particularly through Spain, France, and Italy, according to George M. Ling, director of the United Nations Division of Narcotic Drugs.

Increasing amounts of the drug are being intercepted at various national borders where "they were previously unknown," Dr Ling said in a paper to an international conference here on alcohol and drugs. Most participants were from Latin American countries.

(In Dr Ling's absence, his paper was read by Archer Tongue, executive director of the International Council on Alcohol and Addictions.)

He said the relatively high cost and low purity of cocaine products "outside the countries where the coca bush is prevalent" and its comparatively infrequent use have contributed to the belief that the drug is a non-addictive and non-hazardous innocuous stimulant.

"However, it should be noted that while some reports suggest that cocaine is not physically addicting, its long term chronic use can lead to psychological dependence, vasoconstriction, destruction of the nasal mucous membranes, convulsions, and even death due to arrest of respiration."

He said the struggle against illicit drugs must be tackled from a firm base.

"In the international context, this firm base can only be the practical commitment of individual members states — a commitment which can be expressed in several ways.

"In addition to the ratification of the international treatics, the strength of a nation's commitment is also reflected in the priority given to the matter of drug control.

"This can be measured by the activities undertaken to eradicate illicit supply. It can be measured by the adequacy of the national laws; by the resources allocated to law enforcement to work against illicit traffic; and by the facilities available to prevent and reduce the demand for illicit drugs, and to try to assist drug-dependent people to become useful members of society."

Daytime sedatives plan

WASHINGTON — The United States Food and Drug Administration has proposed restrictions on sales of "daytime sedatives" and a ban, because of cancer fears, of a chemical contained in most sleep inducing products sold over the counter.

The "daytime sedatives" are unnecessary because they can make people drowsy while carrying out a number of tasks, such as driving, FDA Commissioner Donald Kennedy said. The FDA proposal would stop sales of compounds labelled as being good for "edgy feelings" and "simple nervous tensions."

Dr Kennedy said the FDA wants also to ban use of methapyrilene because of a possible link between the chemical and cancer. Methapyrilene is found in the most commonly used nighttime sedatives such as Nytol, Sominex, and Compoz.

Small amounts of methapyrilene have been found to cause liver tumors in rats if they were also fed nitrites.

The proposal to curb "daytime sedatives" is now open to written objections and requests for hearing. It may be more than a year before the ban goes into effect.

Manitoba scrutinizing alcohol programs

WINNIPEG — Programs of the Alcoholism Foundation of Manitoba and the Alcohol and Drug Education Services are being subjected to a thorough examination by the provincial government.

Ken MacMaster, minister of northern affairs in the new provincial government, told the annual meeting of the Alcohol and Drug Education Services it will not receive government funding until its future role has been determined.

Both the education service and AFM are being surveyed through the provincial task force on government organization and economy, the minister said.

He said the government has reservations about the current organization of the AFM. It might be possible for the private sector to deliver programs now in the hands of AFM more efficiently and economically, he added.

In June 1977 the government-run AFM had cut $50,000 from ADES funding and announced it would start training school teachers to provide alcohol and drug education services.

When the Progressive Conservatives under Premier Sterling Lyon won the October provincial election in Manitoba, they froze the AFM budget and cut staff to increase efficiency and return some programs to the private sector.

However, ADES, a private organization offering alcohol and drug education programs to schools, is still being forced to operate on donated funds.

Stanley Steinmann, executive director of ADES, said the organization's field workers have been working since last June without knowing whether they are going to get paid each month.

He said he has offered Winnipeg and other school boards purchase of service plans which have raised about $10,000.

Mr Steinmann said he is confident the province will pay for ADES next year if the AFM education programs are abandoned.

If this were to happen, the AFM would continue alcohol treatment and rehabilitation services, while the private sector would be responsible for education programs, he said.



Ken MacMaster

Washington, DC - Dust Capital of the World

Grim PCP tales may prompt stricter legislation

WASHINGTON — Washington, DC, Detroit, Los Angeles, and San Francisco have become the major centres in the United States for use of phencyclidine (PCP) among young people. Users say DC now stands for "Dust Capital of the World."

The problems users have with PCP were outlined in grim detail to the Senate subcommittee on juvenile deliquency by residents at a drug rehabilitation centre in nearby Bethesda, Md.

The Senate subcommittee is now considering legislation to increase the maximum penalty for sale of PCP from five to 10 years, and to require manufacturers and suppliers of Piperidine, a key PCP ingredient, to file detailed reports of sales to the justice department.

A review of the PCP problem prepared by the National Institute on Drug Abuse (NIDA) says a conservative estimate is that seven million Americans have used the drug. During 1977, more than 100 deaths and 4,000 emergency room visits were associated with PCP use.

One of the youths told Senators that under the influence of PCP he crashed through a wooden door and did not feel pain from a serious head wound. Another said he almost drowned while swimming because he forgot where he was and did not feel himself going under water.

A convicted PCP manufacturer, who is now cooperating with government officials, said in one day he could manufacture 50 pounds of PCP at a total cost of $5,000. This could be sold for at least $5,000 a pound, a total of $250,000.

He said most of the chemicals needed are readily available and can be mixed in ordinary kitchen pots.

The NIDA review said most PCP users are in the 12- to 25-year-old age group. Chronic users may inhale from 100 mg to 1g in a 24-hour period.

Users who swallow PCP find the effects last longer but are less under control. Some users have developed a tolerance to the drug and need increased doses to achieve the same effect.

It has been found that "patients admitted for emergency treatment because of PCP-induced bizarre behavior are more likely to be diagnosed as schizophrenic than as having a toxic drug reaction."

Chronic PCP users have persistent memory problems and speech difficulties, including stuttering. Some of these effects can last up to a year following prolonged daily use.

The NIDA review says better methods for identifying and treating overdose victims needs to be developed.

The effects of PCP "are so unpleasant that many have wondered how the drug could possibly prove popular." It has such a bad street reputation that many people will use it once but not knowingly use it again.

"Yet others enjoy it consistently and use it chronically."

Despite its reputation, PCP use is on the rise. The NIDA review says: "This increased popularity may reflect a change in attitude toward the drug as a result of increased use by smoking, as opposed to oral ingestion, or it may reflect simply the widespread availability of phencyclidine."

Officials 'flabbergasted' by RCMP admission

(from page 1)

Rights Act), the health department has still not admitted making any mistake.

The reason the department is embarrassed and the ministerial investigation has been launched is that the RCMP, which supplies much of the information in the drug files, had somehow failed to block much of the same information from public review in RCMP data banks, as earlier promised.

In other words, the information that the health department had argued was so sensitive it could not be viewed by anyone, is actually available from the RCMP under the same provisions of the Human Rights Act.

The Journal had learned that the RCMP, through then-Solicitor-General Francis Fox, had demanded that the health department's drug files be kept totally secret.

It was only as a result of persistent questioning by **The Journal** that the health department finally checked with the RCMP to find out whether their files, with much of the same information, was also closed to public view.



Francis Fox

The officials in charge of the health department's files were reportedly flabbergasted when the RCMP admitted they hadn't done what they had said the health department had to do.

See Comment by Bryne Carruthers — page 9.

It was also learned by this reporter that the RCMP and the justice department could not have forced the health department to close off the files — as senior health department officials contended.

Federal cabinet unanimity was required only for closing off the whole drug users file from public scrutiny. Without that unanimity, the health minister could still keep certain information (such as information on third persons, or information that might reveal information on police sources of drug intelligence) secret.

Health Minister Begin admitted this involves the discretionary exercise of power by a Minister.

However, Ms Begin said that at least an individual would be able to determine whether a file existed and could ask to see and check some of the file.

In the interview, Ms Begin indicated that the wholesale closing off of the file to review by named individuals may soon be reversed — a process she says requires only the passage of another order in council by the federal cabinet.

Federal officials in charge of the drug files had never admitted, despite numerous interviews, the role the RCMP and the justice department had played in having the drug files closed off in the first place — that is, the fact that the RCMP, through the solicitor general's department and the justice department, had demanded the drug files be kept totally secret, to protect information in the files that could lead to police informants.

Ms Begin said that, to her surprise and the department's surprise, it was only "discovered" after **The Journal** inquiries that in fact the RCMP had not obtained a total exemption for their similar files, despite what former Solicitor General Francis Fox had said would happen in a "close discussion" with Ms Begin on the subject earlier in the year, just before the health department applied for and received the special total exemption for the drug files.

Opening the files wouldn't make bureaucratic sense, said officials.

Ms Begin said the arguments used at the time to justify obtaining a total exemption of the drug files from public scrutiny seemed reasonable: to protect information pointing to informers contained in the police reports.

It has also been determined that the federal cabinet has generally been very careful about granting special exemptions for government files under the Human Rights Act: sources say that, normally, files were exempted only in cases where knowledge of the very existence of a file — such as in continuing criminal investigations, tax or customs cases, or national security investigations — might jeopardize the investigations.

Interviews with officials in charge of the drug files revealed that this rule of thumb could not apply to the drug users' files, since the bulk of the information — the police reports — was only provided after a particular case had been disposed of in court.

However, the health department officials balked; and only pressure from justice and the RCMP led to the total exemption in the case of the drug users' files.

The drug files, according to federal health department officials, are used to generate drug use statistics and to determine the disposition of seized drugs, money, and related goods.

Of the more than 200,000 individual drug files, more than 165,000 of the still-secret drug files are on young Canadians known or suspected of using the illegal cannabis drugs, marijuana and hashish, that the Liberal government has been promising for years to "decriminalize."

At first, federal health department officials in charge of the drug files defended the action to keep the files secret from even the named individuals on the grounds that it was all legal under the Human Rights Act, which allows the government to apply a blanket exemption in very special circumstances involving criminal investigations or national security, for example.

The officials also maintained it would not make "bureaucratic sense" to have sensitive information separated from the files, so that some of the information could be made available for scrutiny by named individuals.

Indications are the department will remove second-hand information.

There are now indications that the department will move to remove much of the second- and third-hand information from the files and rely, for statistical generating purposes at lease, on only conviction statistics collected by the department.

One interesting revelation during the investigation was that the health department relied exclusively on police reports on convictions (and acquittals) and never verified the information supplied by the police.

(The department had previously argued that personal information was needed for statistical purposes to prevent "double counting.")

However, there is now the growing belief that the accuracy resulting from using only conviction statistics obtained from the public record is not significantly different from the accuracy obtained from using the drug files, where there is a greater risk of violations of personal privacy.

In both cases, the health department still doesn't know all of the Canadians who are actually using various drugs.

The drug files have been accumulated systematically during the past two decades; however, it wasn't until the cannabis explosion (and the related police crackdown) in the late 60s and early 70s that the number of files suddenly mushroomed from a few hundred to thousands. And each year, tens of thousands of new files are added, most of them involving cannabis use.



Monique Begin

They vow to rock the political boat

Pot legalization campaign heats up again in UK

By Alan Massam

LONDON — After lying low for some years, those who want to legalize cannabis in Britain have suddenly re-emerged — and there now seems some chance they will succeed.

The awakening of the pot lobby occurred impressively at London's Central Hall (near the Houses of Parliament in Westminster) when the pioneering MP Maureen Colquhoun told more than 350 supporters that the objective should be the abolition of all criminal penalties for possession of cannabis and a legislative program based on the issue of "personal choice." She said: "To achieve this it will be necessary to rock the political boat."

Ms Colquhoun, who is Labour MP for Northampton and known for views which might be regarded by some as eccentric, was speaking at the inaugural meeting of the new Legalise Cannabis Campaign which has a six-point policy document. The LCC campaigners believe:

- Criminal law should play no part in the use of cannabis.
- Penalties for possession and cultivation of cannabis for personal use should be removed with no arbitrary limit on the amount possessed.
- All criminal records for cannabis offences should be expunged.
- Pending reforming legislation, supply of cannabis should not be treated as a serious criminal offence, and offences of supply and possession with intent to supply should not apply where no profit motive is involved.
- Doctors should be permitted to prescribe cannabis.
- Alternative methods of legal distribution of cannabis should be reviewed.

The new Legalise Cannabis Campaign is being organized by a seasoned fighter for drug liberalization, Tim Malyon: "Cannabis is the most widely used illegal drug in the UK today. We estimate that five million people have committed a criminal offence trying it. Yet, despite the enormous amount of research which shows that cannabis does not constitute a major health risk, the government is still dithering about legal changes. Every year they dither, another 10,000 people are likely to be convicted of cannabis offences."

Mr Malyon said these convictions might jeopardize people's employment prospects and their educational and travel opportunities. It was a misconception that British police concentrated on users of "hard" drugs or dealers: about 75% of all drug convictions in the UK involved cannabis. In 1976, about 80% of cannabis convictions were for simple possession and nearly 90% of these involved less than one ounce. "The police will go to the lengths of scraping out pockets and pipes to get a conviction," he added.

"The consequences of conviction and a criminal record are serious. Heavy fines are not uncommon, and in 1975, 599 people were sent to prison and 445 received suspended sentences for simple possession."

Mr Malyon emphasized that an early change in British law would only bring it in line with what is happening abroad. He stressed that 11 states in the United States as well as Holland and Italy had now decriminalized possession of small quantities of cannabis, and that the Trudeau government had made an election pledge to decriminalize in Canada.

"Yet in Britain, possession still carries a maximum penalty of five years imprisonment. The campaign sees this launching meeting as a means of focusing the widespread discontent about the cannabis laws," he said.

The LCC is now planning to lobby trade unions and MPs, with nation-wide speaking tours to back up its claims.

But a change in the law is not expected to occur before the 1980/81 session of parliament. The greatest hopes of the pro-cannabis campaigners are pinned on a report of the government's Advisory Committee on the Misuse of Drugs, expected this autumn, which has been widely tipped as being in favor of liberalization. It is reported that a working party of the committee want significant reductions in penalties for possession of cannabis.

The government will almost certainly be influenced by the recent statement of US President Jimmy Carter (in Congress in August last year) pointing out that penalties for drug possession should not be more damaging than use of the drug iself; the high cost of legal enforcement (it costs about £100 a week to keep a cannabis smoker in prison), and the fact that current drug laws appear to discriminate against the already socially disadvantaged.

Lady Wootton - she achieved what she wanted

LONDON — Baroness Wootton of Abinger, 81, has directed her energies in diverse ways during a long career.

Besides being a former governor of the British Broadcasting Corporation and chairman of the Countryside Commission, she has campaigned against school caning, nationalism in Olympic sport, supersonic air transport, and inhumanity in medicine — to name a few.

But it was the report of an official committee on cannabis, which she chaired, published in 1968, that created something of an uproar. And that was largely the result of misrepresentation she says.

"Actually, I am off drugs now," she told me with a smile when I called during a break in her duties as deputy speaker of the House of Lords.

Lady Wootton is often wrongly believed to have been in favor of the legalization of pot; an indication, perhaps, that when her subcommittee of the Advisory Committee on Drug Dependence urged lighter penalties for use and possession of the drug in 1968, the suggestion was highly controversial in Britain.

The Home Secretary at the time, James Callaghan, roundly condemned the proposal, saying: "To reduce the penalties for the possession, sale, or supply of cannabis, would be bound to lead people to think that the government take a less than serious view of the effects of drug taking. This is not so. It would be entirely contrary to government policy to allow this impression to spread."

'I am not prepared to engage in a campaign for the legalization of cannabis . . .'

Lady Wootton and her colleagues were not actually suggesting that pot was a "less than serious" problem; only that it should be regarded in a different light from hard drugs.

But now she admits to gaining some satisfaction from the fact that the present government, under prime minister Callaghan, has reduced the penalty magistrates can impose on summary conviction for the possession of cannabis.

Under the Criminal Law Act of 1977, it has been cut from the previous six months to three months — one month less than the term recommended by the Wootton Committee.

And Lady Wootton and Jim Callaghan remain the best of friends. He presided at her 80th birthday party.

The baroness told **The Journal** that although it is often assumed she favors legalization of cannabis she would not, in fact, recommend it.

"I am apprehensive of the use of cannabis by motorists and feel that the road safety factor is a very important one," she said. "Also, there is no scientific agreement about the long term effects.

"Only the other day I was approached by someone seeking my support for a new campaign to legalize pot, but I refused. They want my name, but I am not prepared to engage in a campaign for the legalization of cannabis.

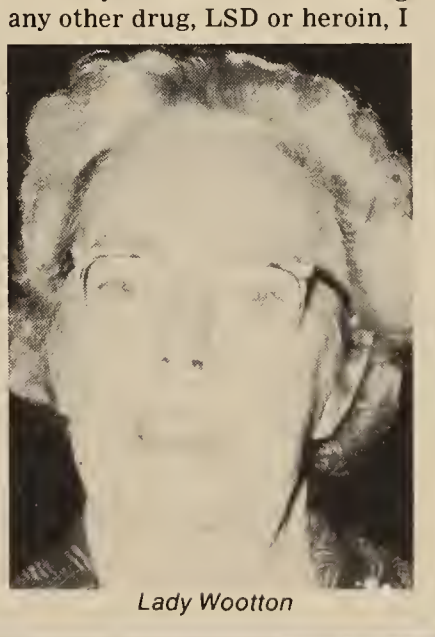
"Essentially, my committee sought to establish a clear distinction between the possession and trafficking of cannabis, and that has now been achieved."

Reflecting on the heated controversy which followed her committee's recommendations, Lady Wootton said: "The differentiation between cannabis and more dangerous drugs such as heroin was new at the time."

She said she was of the opinion that her committee was well informed, and came to the right conclusions on the evidence presented.

Does Lady Wootton still take what is regarded as a liberal view of cannabis?

She has been quoted as saying that she would prefer a child to avoid smoking pot, but would not be too worried if it did so. "But certainly if I found a child taking any other drug, LSD or heroin, I would be very disturbed", she added. "Also, smoking marijuana is against the law and I should very much regret it if a child of mine broke the law."



Lady Wootton

As a magistrate Lady Wootton clearly supports abiding by the law.

But as a life-long Socialist she is someway removed from the establishment. Since the drug rumpus died down she has remained in the limelight of controversy. She introduced an "Incurable Patients Bill" which, while not proposing euthanasia, sought rights for patients to refuse treatment likely to prolong suffering; she tried to persuade the government to scrap the Anglo-French SST Concorde and she urged, in another bill, that teachers should be jailed and/or fined for caning their pupils.

But Lady Wootton's radicalism is perhaps best illustrated by her views on penal reform. She has often expressed disillusionment with the rehabilitative possibilities of imprisonment and favors community service orders, under which individuals must undertake unpaid community work in their spare time, for offenders.

Glue, solvent sniffing hidden but growing

WINNIPEG — Glue and solvent sniffing in the inner city here may have become less visible, but appearances deceive. Sniffing is on the increase, and health and juvenile authorities have cause for more, not less, concern.

David Burnett, an official of the Winnipeg Boys and Girls Clubs charged last month that provincial and city administrations are largely ignoring the sniffing problem in the city core. And a task force should be set up to investigate the situation.

Mr Burnett estimated at least 1,000 young people sniff glue or solvents in Winnipeg at least twice a week. Most of them are Metis or Indians, some are as young as eight years old.

Mr Burnett said poverty and lack of parental support and supervision are at the root of the glue sniffing problem in Winnipeg.

He said when the Non-medical Use of Drugs Directorate of the federal government started to pay the salaries of three workers who were to attack the problem of sniffing in the inner city in 1974, there were gangs of youths sniffing glue and solvents together.

By the time the project ended three years later, each one of the workers had a caseload of 15 youngsters. "Our successes were in the eight-to-13 age group," Mr Burnett said. "Once these kids get past 13, it is hard to deal with them."

Now the gangs no longer exist, so the sniffing problem is less visible. Yet sniffing clearly is on the increase. The youngsters are sniffing in abandoned houses in the Winnipeg core area, and more of them are doing it alone.

"It used to be a boys' problem, but now we are finding an equal number of girls are sniffing."

Mr Burnett said there is evidence girls have more trouble stealing glue or solvent and some appear to be prostituting themselves to get it.

If a task force were set up to study the sniffing problem, it should have authority to gather statistics on sniffing from police, the Manitoba Youth Centre, and the Children's Aid Society, something the three community workers in the inner city were not able to do during the three years of their project.

Mr Burnett said he favored legislation to make sniffing illegal and to tighten regulations on selling glue and solvents.

He also said the provincial government should try to slow the migration of natives into the city by making it more worthwhile for them to remain on reserves and other rural areas from which many of them have migrated to Winnipeg.

Gentlemen's pipe disagreement

WASHINGTON — A gentlemanly, but very determined, tussle has emerged among judges as to whether smoking should be banned in the new $40 million District of Columbia courthouse.

Judges in the superior court division, who occupy the first seven floors of the courthouse, voted to prohibit smoking in all courtrooms and hallways. Big "no smoking" signs are displayed and guards are eager to enforce the ban.

But not on the eighth floor of the courthouse. That is the domain of the higher court of appeals under Chief Judge Theodore Newman. No signs or eager guards here.

Judge Newman, a pipe smoker, has been quoted as saying he knows of no lawful order restricting smoking in the building. One day he was seen wandering the lower floors, puffing his pipe, and only a last second intervention by a colleague prevented a guard challenging him.

Judge Newman has apparently intimated in casual conversation in the lawyers' lounges that if any of them wish to challenge the smoking ban on the first seven floors he will be quite happy to listen to any appeal.

Meanwhile, cigarette ends by the hundreds dot the entrance to the courthouse, and the stale smell of tobacco smoke lingers in the restrooms.

EDITOR
Anne MacLennan

STAFF WRITER/PRODUCTION EDITOR
Karin Pargas

CONTRIBUTING EDITORS
Harvey McConnell (Washington)
John Shaughnessy (Toronto)

SCIENCE EDITOR
Dr Ruth Segal

The Journal

Published by Addiction Research Foundation of Ontario
33 Russell St, Toronto, (416) 595-6053

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Letters to the Editor

Davies no support for controlled drinking

Alan Massam's piece Public in dark about controlled drinking option (**The Journal**, June) makes interesting reading. Nick Heather (whoever Nick Heather is) should not base his opinion on Dr D. L. Davies' 16-year-old opinion that some alcoholics leaving treatment at the Maudsley Hospital were turned into social or controlled drinkers. In fact, we find little in the way of factual criticism that can be done with the D. L. Davies paper for the simple reason it is not a scientific paper. However, readers of *ALFAWAP JOURNAL* Vol 1 No 2 will be treated to a detailed criticism of the Rand Report which will, in our view, bury the subject once and for all.

In the interests of all who suffer with a drinking problem it would be wonderful if social drinking were possible. As it is, the "treatment" causes much unnecessary human misery, insanity, and the early alcoholic grave.

The Rev Ronald Forbes
Managing Editor
ALFAWAP Journal
London, England

Charge of suppressing Rand research is absurd

Nick Heather's remarks on the putative suppression of the research results obtained by Drs Armor, Polich, and Stambul of the Rand Corporation are so poorly informed one wonders why they were given such prominence by writer Alan Massam (**The Journal**, June).

The suppression charge is absurd. In actuality, the results obtained in this study concerning controlled or moderate drinking in alcoholics appeared on the front pages of the *The New York Times* virtually on the day of publication of the report by the Rand Corporation. The findings were released to the press even before they were made available to the scientific community. Coverage of the report was extended throughout the media in this country.

Ironically, no such coverage was given to the National Council on Alcoholism press conference held in Washington shortly after the report appeared. At this conference, a number of people, including myself, from the alcoholism field presented substantial scientific criticism of the findings concerning moderate drinking among recovered alcoholics. Despite the presence of all major television networks, wire services, and reporters, there was a virtual news blackout on this important press conference convened by the NCA.

Mr Heather complains that "copies of the report are now extremely difficult to obtain." He is wrong again. The complete report by Armor, Polich, and Stambul is available in hardcover from Wiley Interscience Books.

Mr Heather asserts the report is, by the standards of research into alcoholism, "which admittedly are low," a "highly competent piece of work." In this instance, Mr Heather is at least partially correct. The statistical analyses presented by the Rand authors are indeed sophisticated, searching, and competent. Unfortunately, sophisticated data analyses alone do not a rigorously controlled study make. The fact remains that the data base so brilliantly analyzed by the Rand authors was generated by a completely uncontrolled experiment in alcoholism treatment.

Aside from numerous questions of experimental design, Mr Heather fails to consider the seriousness of an enormous subject mortality rate. Of an initial sample of 13,661 subjects, a grand total of 9,950 treatment drop-outs occurred. The Rand authors, of course, recognized the serious threat to the validity of their findings of a drop-out rate of this magnitude. They attempted to compensate for it statistically. I remain highly skeptical of this attempt at after-the-fact statistical control.

Despite the fact that the Rand authors claim to find some people with prior diagnoses of alcoholism, drinking within "normal" or "moderate" limits (and there are some 57 prior studies that make the same claim), the critical questions remain unanswered. These are as follows:

How many alcoholics can be expected to do this?

Over what temporal intervals can they be expected to sustain such behavior?

What are the risk factors inherent in various definitions of relatively "moderate" drinking? (For example, considering the havoc that an alcoholic is capable of raising in just one night of uncontrolled drinking, even just two uncontrolled drinking episodes a year in an otherwise "controlled drinker" might prove disastrous).

Can we reliably differentiate persons with prior diagnoses of alcoholism who might be able to drink moderately from those who cannot?

Assuming that controlled drinking becomes an accepted treatment "option" for some alcoholics, does Mr. Heather or, for that matter, anybody else really know how to treat persons to achieve that goal?

Despite all of the scientismic huffing and puffing by Mr Heather and others like him concerning this issue, it is abundantly clear that reliable knowledge about these questions does not yet exist. To insist otherwise is, at best, naive and, at worst, ignorant of the rules of scientific inquiry.

John Wallace, PhD
Director, Alcoholism Services
County of Putnam
Community Mental Health Board
Mahopac, New York



Inside Science

Alcoholism a

By Marie Burnett, PhD

The understanding of alcohol addiction among psychologists and psychiatrists has swung back and forth like a pendulum from the earliest psychoanalytic formulations which held that addictions occur in latent homosexuals with an oral-receptive character disorder highly resistent to treatment; to a disease concept that would interpret addiction as a physiological phenomenon based on the pharmacological characteristics of ethanol interacting in a person with a familial or constitutional nervous system anomaly. And, finally, to the current "nurturance" position taken primarily by behaviorists operating from laboratory settings. This holds that drinking is a behavior like any other that can be shaped and manipulated to prevent and/or cure abuse and addiction in almost any subject regardless or his or her characterological or constitutional vulnerabilities.

While proponents of the disease model insist abstinence is the only effective treatment for alcoholism, behaviorists insist many alcoholics can be taught to drink moderately. While proponents of the disease model claim alcoholism is treatable but incurable, behaviorists claim some alcoholics can be "cured". (Stambul et al 1977) While proponents of the disease model define alcoholism as the inability to control drinking behavior, behaviorists either avoid defining what they mean by alcoholism or define it as simply the bad habit of drinking to excess.

As a clinical psychologist, I am strongly in opposition to a disease model of emotional disorders in my practice with non-alcoholics. However, my experience as director of outpatient alcoholism counselling in a psychiatric clinic setting has convinced me that in working with alcohol addicts and their families, the Jellinek (1972) disease model *correctly* understood is the only one with any pragmatic value.

Further, I am convinced that studies which have challenged this model are riddled with defects growing out of naiveity and rosey-cheeked inexperience with the grim clinical facts ism. Simply put, they have ned" by alcoholics who, as a g ready to cooperate in labora as they were willing in the p years and money on the an Any approach which does n alcoholic to stop drinking w attractive.

A comprehensive theory ism, it seems to me, canno toxicity of ethanol to the org

The metabolism of etha organic systems which alter excessive intake.

The physiologic toxicity o frequently lead to such com respiratory or other infecti esophagitis, gastritis, panc hepatic dysfunction. (*Dr* January, 1978). This me body will "experience" ferently after an extend heavy alcohol intake.

Tissue changes cannot be are to understand and trea Brain dysfunction, for e been documented in chron

Comment

The drug files: protecting empires in Ottawa



By Bryne Carruthers

Trying to get a straight answer out of the Ottawa bureaucracy on the reasons why the federal bureau of dangerous drugs compiles still-secret drug user and distributor files is enough to make anyone cynical about and distrustful of government.

In more than six months of investigation, however, **The Journal** asked enough questions to uncover a major bungle.

Information that the health department said was so sensitive that a complete data bank on drug users had to be kept totally secret, despite the fact it contained information drawn from public files, and mistakes, turned out to be available directly from the source, the RCMP. And it was available as a result of the same provisions of the Human Rights Act that the health department legalists were hiding behind.

The department still hasn't admitted it did anything wrong, only that another federal agency failed to play the same game. As a consequence, the health department was made to look foolish — and certainly the department couldn't put up with that for long.

There is still the chance the government will try to make the situation right by doing another wrong — that is, close off the RCMP files, to join the health department's files in total secrecy.

However, it seems illogical if not illegal that RCMP files that have been allowed open for these many months should suddenly be closed to the public. And that, it seems, is the only reason the health department will finally move in the other direction, and open its files.

Bureaucratic protectionism, it seems, is more powerful than right or wrong, and certainly more powerful than the bureaucratic expediency that prevented the department in the first place from separating out the sensitive information from the rest and making at least some of the drug files open to the people named in them, thereby fulfilling a principle of the Human Rights Act.

However, what was frustrating — and potentially more dangerous — about the experience was the way health department officials treated the whole affair with seemingly total disdain, and the way they managed to deflect legitimate inquiries for so long.

The health department, like other federal agencies covered by the Human Rights Act, has a privacy coordinator who is supposed to make sure the department does everything properly under the Act.

It turns out the privacy coordinator is also given the task of handling public inquires about data banks kept from public view under the Human Rights Act.

If the health department's coordinator is any example, then a mark of federal privacy coordinators is that they don't often know what's in the files covered by the Human Rights Act (nor do they particularly care); and they don't understand or question the reasons why things are done a particular way, such as why the agency decides to close off a particular data bank from any public scrutiny.

Of course, an official who doesn't know anything cannot tell the public anything that is sensitive or controversial. Perhaps that is the explanation.

Then, there are the officials who deal with the particular programs — in this case, the drug files.

Ostensibly, they are willing to provide any information the public might seek — that is, unless someone asks for perhaps the most important information of all, the answer to the question "why?".

Decisions are defended not on the basis of whether it is necessary, or proper, or just, but rather on the basis of whether it fits within a bureaucrat's interpretation of the particular law or a regulation. And since most federal laws are wide enough to allow you to do almost anything, it doesn't take too much bending to cover most situations.

If it's legal, it has to be right. And, for a corollary, if it is hard to justify rationally, find a regulation or legal requirement under which it can be justified.

In the drug files case, the impression is left that past decisions are being defended on the grounds that they have been made, rather than examined on the basis of whether they were the correct decision then or, more importantly, now.

It's a bureaucratic version of protecting empires.

And the way government decisions are made, with so much emphasis placed on the views of "experts," unless someone along the way starts to ask questions, such as "why", the recommendations of experts become the decisions of government with hardly a whimper or a worry.

The controversy over the keeping of secret drug files is more than a question of personal privacy; it involves the more important issue of government accountability to the public on whose behalf it is supposed to be ruling.

If the saga of the drug files is any indication, no wonder Canadians have become cynical and worried about what their country's government is doing.

A dangerous weapon in the war against heroin



By John Shaughnessy

British Columbia has gone too far in its attempt to control heroin addiction.

At best, the province's Heroin Treatment Act offers a three-year, drug-free treatment program designed to change the addict's lifestyle and reduce or eliminate his dependency on narcotics. At worst, it authorizes three years of compulsory treatment for people judged to have a psychic dependence on a "morphine-like substance."

BC moved to counter what it views as an ever-escalating problem in terms of numbers of addicts and costs to society, as well as the failure of voluntary treatment programs.

The fact is, however, that the Act seriously slices into the civil liberties of people in British Columbia without offering heroin addicts realistic prospects of rehabilitation.

The province's health minister, Robert McClelland, is confident the program will work. He believes all addicts subconsciously want to kick their habits and that, given the right program, they can be motivated to change their lifestyles and shake their addictions. No one doubts his sincerity, but surely he is overly optimistic.

The government and its Alcohol and Drug Commission, which is spearheading the program, have so far proposed nothing new in the way of treatment programs. People directed into treatment will undergo any or all of several approaches — behavior modification, job and life skill training, and family counselling. Methadone maintenance will play no part.

Such program plans do not inspire confidence. Even less do their likely success rates justify imposition of compulsory treatment. Mr McClelland admits voluntary treatment programs have been inadequate and suggests that's largely because addicts were not attracted to them. And he allows that the most successful programs have been those where the addicts have a high degree of motivation. Yet, he believes many addicts, particularly those most recently addicted, somehow will accept compulsory treatment.

As examples of compulsory treatment that are showing a high degree of success, the government cites programs in California and New York. Yet, studies from these jurisdictions indicate successful outcomes rarely exceed 10% to 15%.

As Mr McClelland envisages it, the BC treatment program will be a back-up to law enforcement activities and end the revolving door of conviction-release-conviction for addicts.

The Act seriously slices into civil liberties.

Critics see it another way. It's not a health program, they say, but another tool for the police. Possession and trafficking are offences under the federal Narcotics Control Act. Now, people in BC who are neither in possession nor trafficking but who are "judged dependent on a narcotic" can be "directed" into a mandatory three-year treatment program.

Intake in all cases begins with a police officer. To the person on the street "the heat" is "the heat". He will have a tough time believing the police officer is "directing" rather than arresting him.

The Treatment Act itself lends some credence to these claims. Once a police officer serves a notice to a person to appear for evaluation, that person has no right to medical or legal counsel until he or she has been committed for treatment.

In the same vein, critics see the imposition of minimums as punishment rather than treatment. A true treatment program, they argue, would allow for positive responses by individual patients.

Similarly there is skepticism about the make up of the evaluation panel. The Act requires the panel be composed of at least two medical practitioners and "one other member." There is nothing in the Act preventing the "other member" from being a police officer. Critics fear information gained in the evaluation might find its way from the evaluation panel to the BC police authorities, to Ottawa, and then to Interpol.

Mr McClelland is adamant that police are not going to frustrate the credibility of the program. He says the very strictest confidentiality will be maintained concerning information obtained during evaluation. Under the Act, the only information that will be available to the police is the name of an addict and whether or not he is in the treatment program. Nevertheless, the critics are correct when they say there is nothing in the Act to prevent a police officer from being appointed to the evaluation panel.

The courts will have to decide whether the Heroin Treatment Act is truly health legislation and within the jurisdiction of the provincial government, or criminal legislation which is the domain of the federal government.

In a way, that is almost irrelevant. Whatever government has jurisdiction, the fundamental questions have not been satisfactorily answered. In a democratic society what kind of behavior jusitifies compulsory treatment and potential confinement by the state? Will the compulsory treatment and potential confinement be of benefit to the individual and the society?

The evidence currently available suggests the health damage from heroin addiction is considerably less than that suffered by those addicted to alcohol. The social costs of heroin addiction are magnified because it is an illegal drug and, as a result, heroin-related crime and the drug subculture are involved in the problem.

Society has higher values than the treatment of addiction.

Even maximum security prisons have been unsuccessful in their attempts to remain drug-free. The chances of BC's detention centre and out-patient centres achieving this objective are slim.

Most importantly, the success rates of the treatment programs being suggested in BC are not high enough to warrant compulsory treatment.

Ultimately, we must face the fact that any democratic society has higher values than the treatment of drug addiction. The seeming beneficence of compulsory treatment ought not to serve as a justification for diminishing civil rights. It ought, rather, to alert the BC government to the possibility that in its rush to reap the supposed benefits it may be ignoring the implications of its actions.

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An anesthetized brain will "experience" alcohol and all other aspects of life differently. Treatment approaches which focus only on social-psychological aspects of the client's life-space will fail to arrest the progression of organic alcohol deterioration.

Behaviorists who would solve the problem of alcohol abuse by teaching people how to drink moderately, fail to understand that alcohol abusers use alcohol to get drunk. Such abusers are not interested in alcohol as a beverage. It is as absurd to suggest alcohol abusers would like to learn how to avoid inebriation, as it is to think pot smokers would like to learn how to smoke reefers without getting high.

Programs designed to educate abusers to the advantages of using alcohol moderately have not been designed by clinicians who have listened to what abusers say about their drinking. If they had, they would see how far off the mark such approaches are. We need to keep in mind that it is "the experience" abusers are after: the alcohol, or pill, or drug is merely a means to that end. To ignore the *motive* that propels the behavior is to ignore the most essential component to the understanding of substance abuse.

A more meaningful and to-the-point learning approach to substance abuse would be to teach people how to enjoy being straight — how to pass time in a more satisfactory way, how to derive satisfaction from relationships, how to achieve intimacy, how to avoid boredom. People who enjoy being straight do not have to be taught how to drink moderately because they do not drink to get drunk.

The disease concept as put forth by Jellinek, on the other hand, does not ignore the role of psychological motivations in understanding alcoholism. Abusive patterns of alcohol use serve psychological needs and motivations which over a period of time will usher in an addiction in persons with a physiological vulnerability.

Dr Burnett is chief psychologist and director of Saint Francis Hospital Outpatient Alcoholism Counseling, Evanston, Illinois.

Family docs are vital in alcohol work

LONDON — The family physician has a vital role in the prevention, early detection, and treatment of alcoholism, a survey has shown.

In fact, Benno Pollak claims a large number of alcoholics hidden in general practice can be identified by simple screening methods.

"Although it would be impractical to screen every practice patient, alcoholism should always be considered in the differential diagnosis of puzzling cases," Dr Pollak says in the *British Journal on Alcohol and Alcoholism* (vol 13.1.1978).

Dr Pollak, who has a group practice in South London, reports that with colleagues he set up a special register of patients suspected of being pathological drinkers.

The patients were approached by letter and offered medical examination. Of the 195 patients on the register, 26 failed to answer the letter, 18 could not be traced (a total of 22.5%), and 12 (6.2%) were excluded on account of age (study restricted to 20 to 70 age group). Two alcoholics were also excluded because they had been sober many years and four more patients were not assessed as they had moved before consultation could be arranged.

Of the 133 patients thus coming within the terms of the study, 69 were diagnosed as alcoholics. Of these, 57 completed a two-year treatment program.

At followup, 11 (19.3%) were abstinent; 26 (45.6%) improved and 20 (35.1%) unchanged after two years of treatment.

Dr Pollak says there are innumerable problems which alcoholics may present to their family physician, and in compiling the practice register, he and colleagues agreed on 33 key indicators including recurrent gastrointestinal symptoms, unexplained pulse irregularity, smell of alcohol on the breath or unexplained large drink supply at home, depression, and requests for advice on alcohol abuse from patient or relatives.

Dr Pollak concludes that treatment of alcoholics is feasible in general practice and the notion that it requires special expertise has not been substantiated.

Opium crop substitution gains ground

By Thomas Land

GENEVA — Australia and New Zealand are expected shortly to follow the Nordic initiative by releasing development aid funds to finance crop substitution projects in South-east Asia in an effort to attack the illicit opium trade at source.

Northern Europe's first major response to the challenge of opium traffickers was made by Norway last summer when it announced a multi-million dollar crop substitution and public health project to be implemented in Burma. The other members of the Nordic Council followed suit; and they also urged prosperous countries to join them in a generous and rational approach to eliminating the supply of illicit drugs by providing opium poppy growers an acceptable alternative means of livelihood.

Senior government spokesmen from Australia and New Zealand have now assured Dr Bror Rexed, executive director of the United Nations' Fund for Drug Abuse Control in Geneva, of financial support for such schemes, which have already begun in Thailand.

"The objective of these plans," explained a UN spokesman, "is to eliminate the illicit growth of opium poppy by the extension of the results of pilot crop substitution and community development projects through programs of integrated rural development in the opium growing areas."

Australia promised it would "consider favorably" requests by the affected governments for the provision of development assistance funds for integrated rural development activities with the ultimate objective of replacing illicit narcotics cultivation.

The spokesman for New Zealand also expressed support for the crop substitution program which he described as "urgently necessary". He added his government was eager to participate in a major extension of the projects currently under discussion by the UN agency, the governments of the opium producing countries of the region, and the donors.

Both Australia and New Zealand are likely to follow their diplomatic move by drastic measures at home to cut trafficking.

Both administrations are under intense parliamentary pressure to act, after the discovery of large consignments of illegal drugs brought in by private aircraft and boats; both have promised to save no effort in strengthening the national narcotics law enforcement agencies; and both are considering severe new penalties for offenders.

In New Zealand:

School smoking plan fails

WELLINGTON, NZ — A seven-month experiment to modify the smoking habits and attitudes of 428 New Zealand school children aged 12 to 15 has failed.

In the intervention program tested, teachers were encouraged to introduce the subject of smoking in a low-key, non-directive way whenever it seemed appropriate in a variety of class subjects. Fear-arousal methods were specifically avoided.

The teaching approach included five basic steps: problem awareness (analysis of cigarette advertising); problem importance (analysis of community health problems and the smoking/health relationship); personal relevance and susceptibility (description of the short term effects of smoking on health); susceptibility of the problem to intervention and control (analysis of changes in New Zealand doctors' smoking habits, role-play strategies against pressures to smoke); and commitment to action (possible pupil-initiated action against cigarette smoking).

When smoking habits and attitudes were remeasured and compared with those in a comparable school using traditional anti-smoking education (films and informal discussions), no change was found at either school.

Of the total 997 children, 15% smoked more than two cigarettes a day, and 17% smoked one or two. An unchanged 83% believed smoking causes cancer.

Discussing the failure of the program, the study team from the epidemiology unit at Wellington Hospital said there was extensive use of audiovisuals but less written material. Science and physical education teachers appeared better able than other teachers to use the material provided. And, with 20% of teachers regular smokers, teaching enthusiasm "varied considerably."

Suggesting the program may have been too late, the team reported that 84% of the child smokers said they had started before age 12.

Mass media promotion should be restricted

UN calls for higher tobacco taxes

GENEVA — The United Nations World Health Assembly has called for higher taxes to be levied on cigarette sales and for restrictions to be imposed on tobacco promotion in the mass communication media.

The assembly blamed tobacco smoking as a major cause of chronic bronchitis, emphysema, and lung cancer, and as a major risk factor in heart attacks, some pregnancy-related disorders, and other serious health problems. Delegates also emphasized the harmful effects of smoking on non-smokers.

A resolution approved by the assembly called on the member states of the UN's World Health Organization (WHO) to strengthen health education programs about smoking as part of general health education, through close collaboration among school and health authorities and other relevant agencies.

It urged comprehensive measures to control smoking by increasing taxation on cigarette sales and restricting, as far as possible, all forms of publicity for the promotion of smoking. It also affirmed the rights of non-smokers "to enjoy an atmosphere unpolluted by tobacco smoke".

The resolution also asked the WHO to cooperate with its member states, upon request, in developing measures to control smoking publicity in the communication media.

The sponsors of the resolution included Italy, Holland, New Zealand, Saudi Arabia, and Britain. They produced statistics showing that world production of cigarettes increased almost threefold during the 25 years from 1950 to 1975 — from 1,139,000M to 3,112,000M. In the Eastern Mediterranean countries, production during the same period increased more than nine times.

Cigarette consumption has also increased alarmingly in some countries where the habit was not previously widespread. Delegates expressed serious concern at this development, and at the extensive promotion of cigarette sales aimed at inducing young people in particular, to start smoking.

Addict, alcoholic, criminal lumped together by GPs

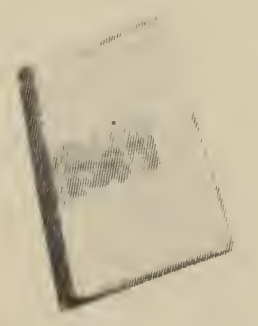
MONTREUX, SWITZERLAND — General practitioners in Yugoslavia are probably like general practitioners everywhere. A study at the University Hospital in Zagreb, which was reported to the World Conference on Family Medicine/General Practice here showed GPs lumped drug addicts, alcoholics, and criminals in the same category. And they associated all three with such words as "bad, cruel, unthankful, unacceptable, ugly, dirty, unhealthy, and distasteful."

Dr V. Iludolin told the World Congress these words reflected the emotional feelings of the physicians toward treating alcoholics, despite the fact the so-called "medical model" of alcoholism is usually accepted by the general practitioners.

The study also showed that doctors' attitudes toward other psychic disturbances such as schizophrenia and neuroses were positive, and "similar to their attitudes toward diseases in general. Such attitudes toward the alcoholic, however, impede the efficient inclusion of general practitioners in the communal program for prevention and control of alcohol related problems."

Efforts are being made, however, with both short term and long term post-graduate courses now being offered to the general practitioners, the latter resulting in a degree in alcohology. To date, about 80 of Yugoslavia's approximately 1,200 or so general practitioners have been involved in this, said Dr Iludolin. The number is expected to increase.

Education of the medical profession, he added, requires awareness that long term treatment — possibly five years — may be involved. And, just as the doctor doesn't give up on the diabetic with difficulties in that period of time, so he shouldn't give up on the alcoholic who has a few relapses.



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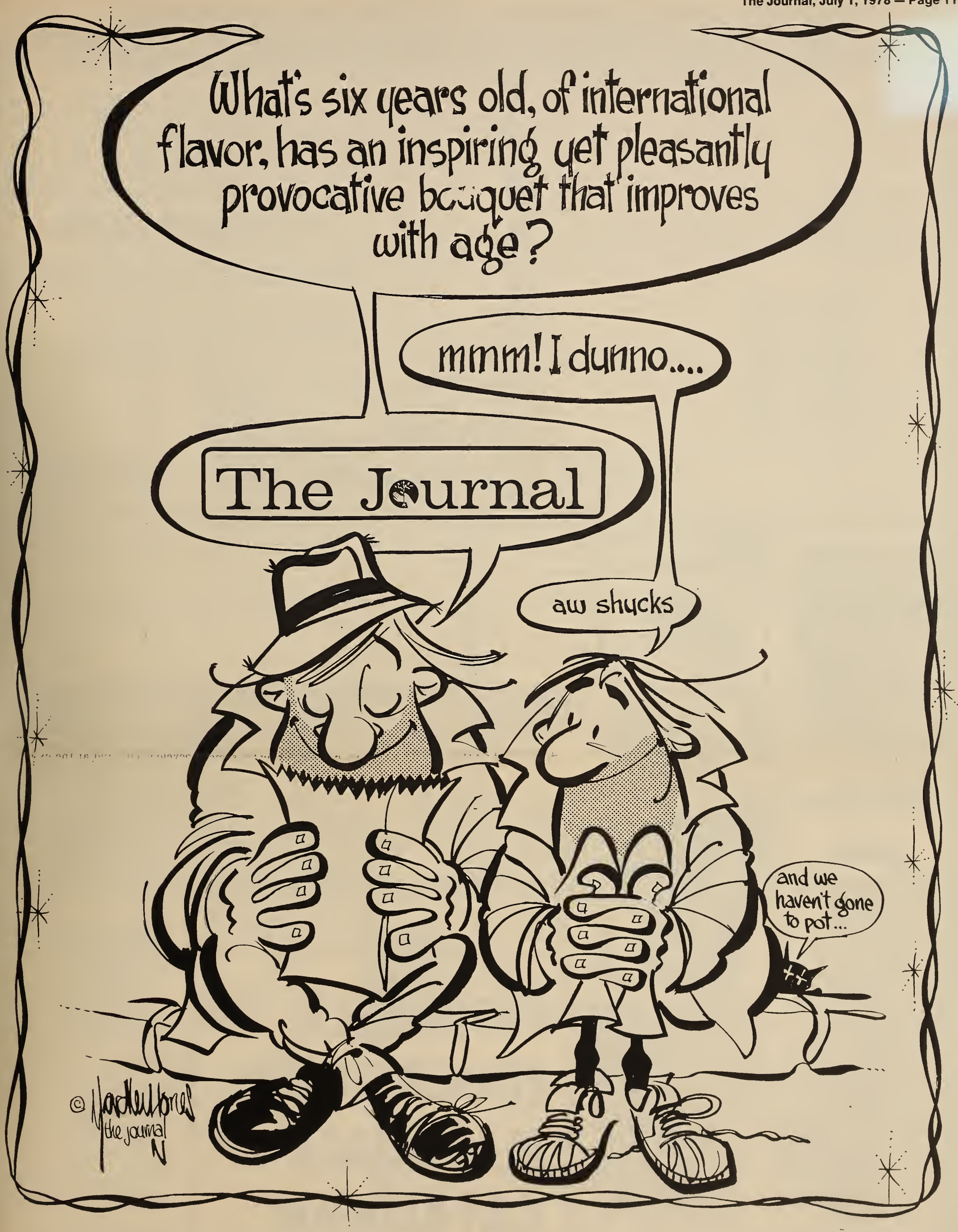
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Love at root of women's alcoholism:Kirkpatrick

By Edith Robb

MONCTON — A professional sociologist says a woman's all-encompassing need to express love is at the root of all her alcohol problems.

Jean Kirkpatrick of Quakertown, Pa, founder and president of Women for Sobriety, says when a woman feels her love is not needed, she is filled with a sense of unworthiness. Sometimes she turns to drinking to ease this emotional pain.

Dr Kirkpatrick, who personally fought the alcoholism battle for some 25 years, said women drink to compensate for a low self-esteem. Often their problems are promoted by such things as the breakup of a marriage, by death or divorce, or the leaving of one of their children from home.

"Alcohol gradually becomes a personality dimension, relieving boredom and alienation."

North American society's mania for youth "that makes a woman of 40 feel worthless in the labor force" is another factor that could account for an increasing number of female alcoholics, she said.

The pattern the female problem drinker follows until she is solidly addicted is essentially the same in all cases, said the sociologist. She sketched the steps.

"At a critical period, like at a time of crisis, a women's drinking suddenly increases. She finds at a party that drinks are not served fast enough, that they are not strong enough. She may even offer to help make them so she can put extra alcohol in hers.

"She starts suggesting to friends that they meet her for lunch and have a couple of drinks. She finds herself visiting only her friends who drink. She starts having a drink before she goes out in the evening; a drink before someone is coming in for an evening; a drink before she goes to the dentist, etc."

Dr Kirkpatrick said our image of the skid row drunk is false: "In fact, only about 4% of female alcoholics end up there. The other 96% attempt to lead their lives in an almost-normal fashion. They continue to work, but they often miss Mondays.

"Alcohol gradually becomes an obsession; something the woman must orient her life around. Soon she has devastating hangovers, so she takes a drink early in the morning to relieve her symptoms."

And since the woman may be secretly covering up her symptoms, such as shaking and perspiring, often the public is unaware of what is happening. Instead, they find the woman unusually animated, enthusiastic, and full of energy.

"The alcoholic woman puts on the greatest act in the world," she added. "They measure their actions, their smiles, so their symptoms won't show.

"The most tragic thing about this process is that the woman herself is the last one to know. Self-deceit is part of addiction. Once in a while, someone like a family member may reach her during the early morning and solicit promises from her-she will never drink again. The family member believes this because he wants to. When the woman fails to keep her promise, the family just becomes more demanding, more disappointed. The woman drinks more to cover her upset feelings."

At this point, women are beyond helping themselves. And sadly, the family will rarely accept the responsibility of facing the truth. They wish for the impossible: that the problem will just go away."

Women for Sobriety, a non-profit organization that began in 1975 and now has branches throughout Canada and the United States, is geared to giving women problem drinkers a chance to share and solve problems in a "women only" setting.

Dr Kirkpatrick was interviewed during a recent visit to Moncton, NB where she was laying the groundwork for the establishment of a new WFS branch.

Paraquat spray Mexico's concern

WASHINGTON — A federal judge has decided he has no jurisdiction over whether the United States government should use its best efforts to try and get Mexico to stop spraying paraquat on illegal marijuana crops.

US District Judge Joseph Waddy made his ruling in turning down an injunction request by the National Organization for the Reform of Marijuana Laws (NORML) to stop American financial aid to Mexico for crop spraying.

He did order the US government to prepare an environmental impact statement about the effects of the marijuana and opium poppy crop eradication program.

The injunction was sought following reports some 20% of the marijuana now reaching the US from Mexico is tainted with paraquat.

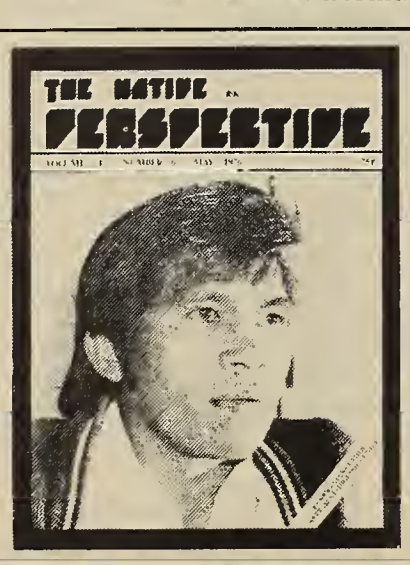
Oscar Flores, Mexico's attorney general, said in a letter submitted as evidence that his country will continue to spray illegal crops even if American aid is cut off.

"Mexican determination to continue combatting crimes against the public health will not falter," he wrote.

Attorneys for the department of state, Agency for International Development, and Drug Enforcement Administration contended the spraying program is directed towards eradicating plants producing marijuana and heroin, both illegal substances.

An appeal of the decision has been filed by NORML, but it is expected to be many months before it is heard.

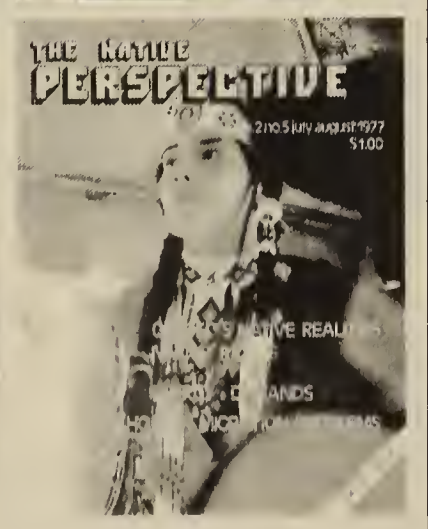












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Around the World

Drink problems

The number of people seeking help for alcohol problems in Glasgow, Scotland, rose 60% in 1977. The Glasgow Council on Alcoholism dealt with 316 new cases during that year, according to its annual report.

Aussie 'tradition'

Australia is a society of heavy drinkers, drug users, and cigarette addicts, an official government report claims. The report — *Drug Problems in Australia — An Intoxicated Society* — says alcoholism has now reached epidemic proportions, and has caused 30,000 deaths in 10 years. As many as 10% of school children aged between 10 and 17 years get drunk at least once a month, it says. And the lives of an estimated 1.4 million Australians are affected by alcohol, at a cost to the community of more than $500 million a year. The study found also that Australia suffers the world's highest incidence of kidney disease through the abuse of pain-killing drugs. Some people use as many as 50 analgesics a day. Australians are heavy smokers also, with each citizen smoking the equivalent of 200 cigarettes a month for every man, woman, and child in the population.

Foam figures

World beer consumption reached 17,050,000,000 gallons in 1975, rising by 550,000,000 gallons over the previous year's world total.

Kirk alarmed

Traditional moral values have been turned upside down, the General Assembly of the Free Church of Scotland has been told by its social responsibility committee. The committee's report criticizes the Sunday opening of public houses which took effect in Scotland last fall. "Those who contend longer opening hours will lead to less drunkenness betray, we fear, a sad ignorance of human psychology, and of the narcotic potency of alcohol," the report says.

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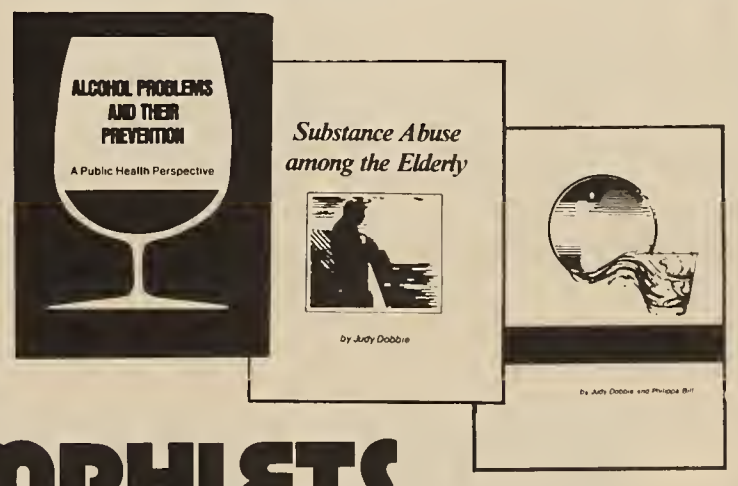
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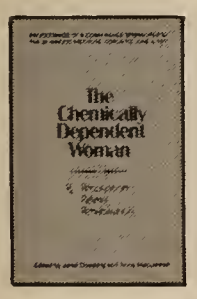
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New Books

by RON HALL

Drinking: Alcohol in American Society — Issues and Current Research

. . . edited by John A. Ewing and Beatrice A. Rouse

This book was written to provide a current review and a reference guide for individuals interested in understanding the significance of alcohol use in American society. It provides a synthesis of previously reported work as well as new research, and a variety of viewpoints which should stimulate the readers' thinking regarding the role of alcohol in society. The text is divided into five parts including; introduction and history, complications of drinking, psychosocial aspects of drinking, social policy and drinking, and a summary.

(Nelson-Hall Publishers, 325 West Jackson Boulevard, Chicago, Illinois, 60606. 1978. 454p. $8.95.)

Perspective On The Treatment Of Alcoholism

. . . edited by Marshall J. Goby and John E. Keller

The articles in this monograph represent a viewpoint that approaches alcoholism as a complex illness which requires a comprehensive and integrated treatment system delivered through a multidisciplined staff. Articles have been included which deal with: a basic philosophical orientation to the treatment of alcoholism; issues to consider in developing and operating a treatment program; specific strategies of treatment and intervention; and evaluation efforts aimed at assessing the quality and effectiveness of various components of the treatment program.

(Alcoholism Treatment Center, Lutheran General Hospital, 1775 Dempster St, Park Ridge, Illinois, 60086. 163p. $5.)

International Collaboration: Problems and Opportunities

. . . edited by Barbara Rutledge and E. Kaye Fulton

This volume is the proceedings of a symposium held in Toronto, Canada on the occasion of the designation by the World Health Organization of the Addiction Research Foundation as a Collaborating Centre for Research and Training on Drug Dependence. Participants from Switzerland, the West Indies, the United States, India, Nigeria, Mexico, Hong Kong, Brazil, and Canada consider topics dealing with epidemiology, control strategies, and international collaboration in drug abuse programs. These included discussion of epidemiological research in the Caribbean and Latin America, the drug-related problems in Nigeria and Mexico, social control as a factor in non-medical drug use, the role of alcohol and drug control legislation, the role of the WHO in the drug dependence program, and international cooperation in drug abuse prevention.

(Addiction Research Foundation, 33 Russell St, Toronto, Ontario, M5S 2S1. 1977. 206p. $14.95.)

Other Books

Drug Metabolism And Alcohol: A Survey Of Alcohol-Drug-Reactions-Mechanisms, Clinical Aspects, Experimental Studies — Pirola, R.C. University Park Press, Baltimore, 1978. Index. References. 175p. $36.

Tales Of Hashish: A Literary Look At The Hashish Experience — Kimmens, A. C. (ed). William Morrow and Company, Inc, New York, 1977. Index. 283p. $5.95.

A Treasury Of Hashish — Sumach, A. Stoneworks Publishing Company, Toronto, 1976. Illustrations. Bibliography. 154p. $5.49.

Drinking: Alcohol In American Society — Issues And Current Research — Ewing, J. A., B. A. Rouse, (eds). Nelson-Hall, Chicago, 1978. History, medical complications, social and psychiatric considerations, psychological aspects, teenage and college drinking, highway safety, social policy and legal controls.

Alcohol And Human Memory — Birnbaum, I. M., Parker, E. S. Lawrence Erlbaum Associates, New Jersey, 1977. Memory and intoxication, alcohol and state dependency, Korsokoff patients. 220p. $12.95.

Diagnosis And Treatment Of Alcoholism For Primary Care Physicians — Addiction Research Foundation, Ontario Medical Association, Toronto, 1978. Definitions, diagnosis, treatment. Appendix. 39p. $1.95.

Women And Alcohol: A Guide For State And Local Decision Makers — Homiller, J. D. Alcohol and Drug Problems Association of North America, Washington, 1977. Council of State Authorities, understanding the problem, collection and utilization of data, treatment of alcoholic women, outreach strategies, prevention, training. References. 100p. $7.

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six point scale. For further information, contact Linda Chung, coordinator of the group at (416) 595-6150.

Alcoholism: The Bottom Line

Subject Heading: Alcohol and alcoholism overview, employee assistance programs.
Details: 29 minutes, 16 mm, color, sound.
Synopsis: Through a series of case studies, the effect of alcohol abuse on workers is shown. In each case there is an attempt to handle the situation, and both negative and positive approaches are shown. Lorne Greene comments with statistics, and urges employers to explore employee assistance programs. He maintains that receiving help is a life-and-death matter for the employed alcoholic.
General Evaluation: Very good (4.8). This film was deemed contemporary, highly informative, and with a clear message. With its appropriate length it was judged a good teaching aid that could lead to attitudes opposed to drug misuse.
Recommended Use: This film was felt to be of benefit to adult audiences, especially those involved in employee assistance programs.

Father Martin: Guidelines

Subject Heading: Alcohol and alcoholism overview, guidelines
Details: 45 minutes, 16 mm, color, sound.
Synopsis: Father Martin addresses an audience concerning eight guidelines in working with alcoholics. He urges people who wish to help the alcoholic, to be aware of their own attitudes, learn to recognize and know what being addicted to alcohol means, and to make alcoholics responsible for their own behavior. Father Martin urges also that the audience not "go it alone", but use community resources, and not get discouraged. His talk is punctuated with humorous anecdotes and jokes to emphasize his points.
General Evaluation: Fair (2.9). Although this film was judged informative, it was a long film and was not seen as a good teaching aid. It received moderate ratings in all other categories.
Recommended Use: This film would be of special interest to church groups and families of alcoholics.

ADDICTION RESEARCH FOUNDATION **NEW RELEASES**

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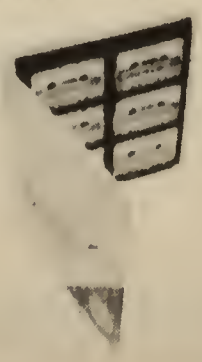
AT-013 CHANGING THE DRUG DEPENDENT LIFESTYLE
21 minutes *by Anne McKay*
Lifestyle change is a difficult challenge facing alcohol and drug abusers. Anne McKay, formerly an occupational therapist with the Addiction Research Foundation of Ontario, discusses leisure related problems, leisure counseling, and the basics of a leisure service. Program planners, counselors, occupational therapists, and recreationists should find this information useful, not only in assisting alcohol and drug abusers but also in developing preventative mental health, pre-retirement, community re-entry, and other lifestyle change programs.

AT-014 SOLVENT AND AEROSOL ABUSE
25 minutes *by Alec Gabe, Frederick Glaser, and Adrian Wilkinson*
What are solvents and aerosols? Who abuses them and why? What can the community do about it? These questions and others are explored in a wide-ranging discussion including Mr. Alec Gabe, information counselor; Dr. Frederick Glaser, head of psychiatry; and Dr. Adrian Wilkinson, clinical psychologist; all with the Addiction Research Foundation of Ontario. Approaches to the management and control are presented along with a discussion of the evaluative process.

AT-015 DRINKING-DRIVING COUNTERMEASURE PROGRAMS
24 minutes *by Pamela Ennis*
The focus in this presentation by Dr. Pamela Ennis, a scientist with the Addiction Research Foundation of Ontario, is on drinking-driving countermeasure programs. Strategies of primary, secondary, and tertiary intervention are considered and their effectiveness is discussed in the context of general and specific deterrence.

OTHER CURRENT TITLES

AT-001 PREGNANCY AND DRUGS — *by Barbara Tucker*
AT-002 FAMILY THERAPY — *by Reesa Kassirer*
AT-003 WOMEN AND PSYCHOTROPIC DRUGS — *by Ruth Cooperstock*
AT-004 COUNSELLING THE CHILDREN OF ALCOHOLICS — *by Kathleen Michael*
AT-005 DETOX CENTRES — THE ALTERNATIVE — *by Dianne Hobbs*
AT-006 COCAINE — *by Oriana J. Kalant*
AT-007 CONTROLLED DRINKING CONTROVERSY — *by Norman Giesbrecht*
AT-008 THE WOMAN AND HAZARDOUS DRINKING — *edited by Deborah Levine*
AT-009 TEENAGE DRINKING: USE AND ABUSE OF ALCOHOL — *by Reginald G. Smart*
AT-010 EMPLOYEE ASSISTANCE PROGRAMS: An Overview for Employers — *by Bryan White*
AT-011 OUTPATIENT TREATMENT OF THE ADULT ALCOHOLIC — *by Michael Jacobs*
AT-012 DRUGS AND THE TEENAGER — *by Dana L. Farnsworth and Michael Jacobs*



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Coming Events

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Canada

The College Of Family Physicians Of Canada Annual Meeting — Sept 10-16, 1978, Charlottetown, Prince Edward Island. Information: Donald Rice, executive director, The College Of Family Physicians of Canada, 4000 Leslie St, Willowdale, Ontario, M2K 2R9.

Alberta Alcoholism And Drug Abuse Commission Summer School On Alcohol And Drugs — Sept 22-23, 1978, Kananaskis, Alta. Information: Marg Bailey, AADAC Community Extension Services, 2nd floor, 812-16th Ave SW, Calgary, Alta, T2R 0T2.

The College Of Family Physicians Of Canada (Ontario chapter) Annual Meeting — Oct 16-18, 1978, Toronto, Ont. Information: Marcia Barrett, 4000 Leslie St, Willowdale, Ont, M2K 2R9.

Canadian Psychiatric Association Annual Meeting — Oct 18-20, 1978, Halifax, Nova Scotia. Information: Dr A Cote, secretary, Canadian Psychiatric Association, Suite 103, 225 Lisgar St, Ottawa, Ontario, K2P 0C6.

United States

Joint Conference Of The American Association For Automotive Medicine And 7th International Association For Accident And Traffic Medicine — July 10-15, 1978, Ann Arbor, Michigan. Information: AAAM executive-secretary, PO Box 222, Morton Grove, Illinois, 60053.

20th Annual International School Of Alcohol Studies — July 16-21, 1978, Grand Forks, North Dakota. Information: Department of Conferences and Institutes, Division of Continuing Education, Box 8277, University Station, University of North Dakota, Grand Forks, ND, 58202.

13th Annual Teenage Institute On Alcohol And Other Drugs — Aug 6-10, 1978, Granville, Ohio. Information: Elaine Zabor, Teenage Institute Director, Division of Alcoholism, Ohio Department of Health, PO Box 118, Columbus, Ohio, 43216.

1978 Summer Institute On Drug Dependence — Aug 27-Sept 1, Colorado Springs, Colorado. Information: Summer Institute, PO Box 2172, Colorado Springs, CL, 80901.

Alcohol And Drug Problems Association Of North America Annual Meeting — Sept 24-28, 1978, Seattle, Washington. Information: Lynn Buttorff, executive assistant to director, ADPA, Suite 204, 1101 15th St NW, Washington DC, 20005.

American Association For Automotive Medicine — Oct 3-6, 1978, Louisville, Kentucky. Information: AAAM executive-secretary, PO Box 222, Morton Grove, Illinois, 60053.

Association Of Labor-Management Administrators and Consultants On Alcoholism Annual Meeting — Oct 4-6, 1978, San Francisco, California. Information: ALMACA, 11800 Sunrise Valley Drive, Suite 410, Reston, Virginia, 22901.

Youth, Alcohol And Social Policy Conference — Oct 19-20, 1978, Arlington, Virginia. Information: Gail Dickerson, Program Director, Health Education Foundation, 600 New Hampshire Ave NW, Washington DC, 20037.

3rd Southeastern Conference On Alcohol And Drug Addiction — Nov 29-Dec 3, 1978, Atlanta, Georgia. Information: Conway Hunter Jr, Medical Director, Addictive Disease Unit, Peachford Hospital, 2151 Peachford Rd, Atlanta, GA.

Abroad

International Round Table For The Advancement Of Counselling And 8th International Conference Of Counselling — July 2-6, 1978, Oslo, Norway. Information: Canadian Guidance and Counselling Association, c/o Faculty of Education, University of Ottawa, Ottawa, Ontario.

5th Institute On Drugs, Crime, And Justice In England — July 11-29, 1978, London, Eng. Information: Arnold Trebach, director, Center for the Administration of Justice, The American University, Washington DC, 20016.

19th International Congress Of Applied Psychology — July 30-Aug 5, 1978, Munich, Federal Republic Of Germany. Information: Travelaide Ltd, 4450 St Denis St, Montreal, Quebec, H2J 2L1.

32nd International Congress On Alcoholism And Drug Dependence — Sept 3-8, 1978, Warsaw, Poland. Information: International Council on Alcohol and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

3rd World Conference Of Therapeutic Communities — Sept 17-22, 1978, Rome, Italy. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Representation Of Alcoholism In Cinema And Television — Sept 25-29, 1978, London, England. Information: The Secretary, Representation of Alcoholism Course, Alcoholism Education Centre, The Maudsley Hospital, 99 Denmark Hill, London SEA 8AZ.

International Symposium On Alcoholism And Drug Dependence — Oct 16-20, 1978, Sao Paulo, Brazil. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

9th International Institute On the Prevention And Treatment Of Drug Dependence — April-May 1979, Manila, Philippines. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

25th International Institute On The Prevention And Treatment Of Alcoholism — June 1979, Tours, France. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

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Circulation: 10,019
(Ontario, 6,718; other provinces, 711; USA 2,320, foreign, 270). Bulk, 3,000; Media 1,093

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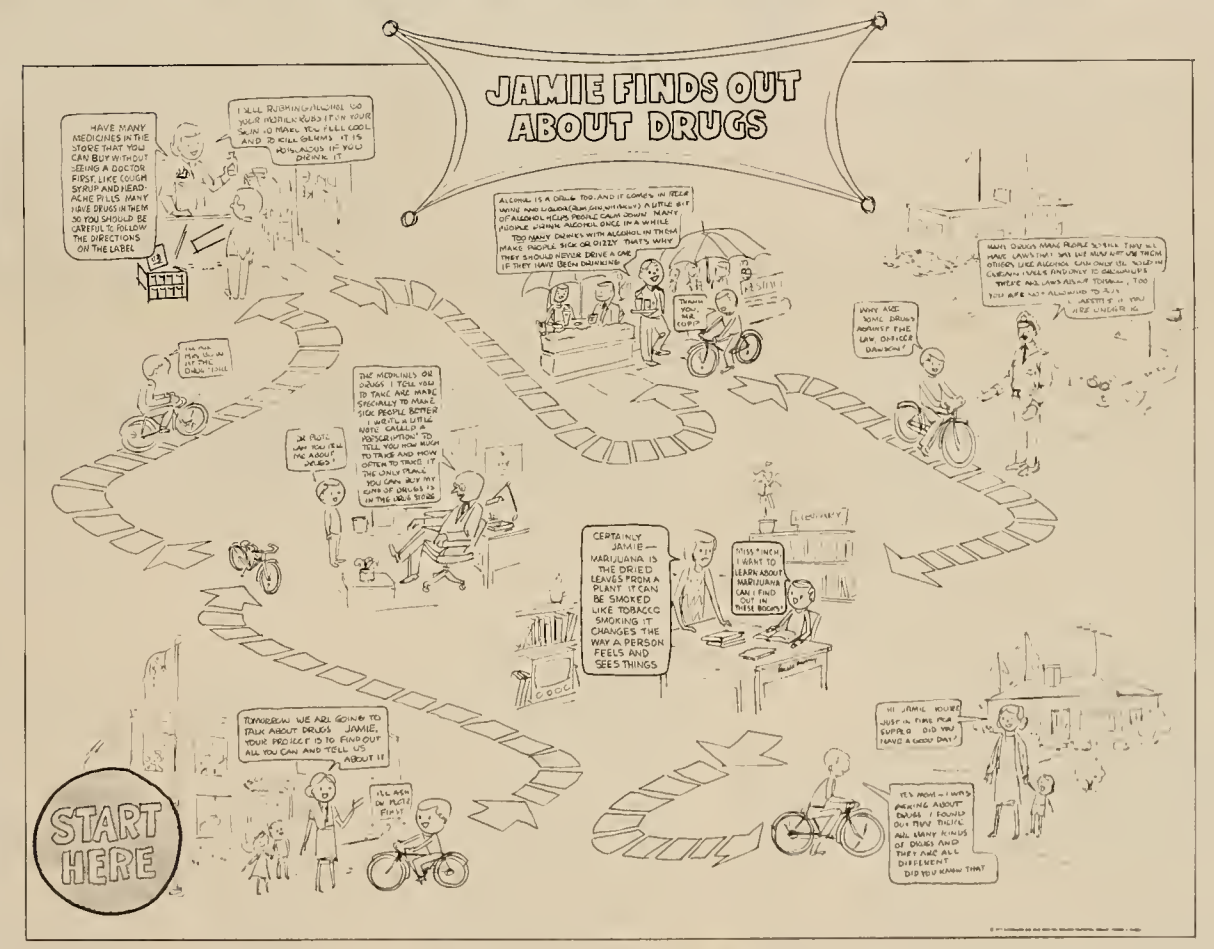


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Critics say 'health law' denies fundamental liberties

BC forces heroin addicts into treatment

By John Shaughnessy

VANCOUVER — Heroin addiction is a communicable disease, in the eyes of the British Columbia government.

And to combat this, the government has passed legislation "to identify and treat heroin and related narcotic users." The Heroin Treatment Act (Bill 18) authorizes a compulsory three-year treatment program for people found to be dependent on a narcotic, and potential detention for six month periods in special cases.

Robert McClelland, BC's health minister, told **The Journal** the province "has been chipping away at the heroin problem for probably 40 years without any real results except to see the problem grow year by year.

"We're considering that heroin addiction is a communicable disease and that it requires some element of direction into treatment. Our problem is growing and there is a demand from the public to take some type of positive action.

"In addition, voluntary treatment programs have had little success in attracting patients. We feel the only way we can achieve any kind of impact on the problem is to have a way in which we can bring people into treatment, and so we've decided on a compulsory program."

THE BACK PAGE

Plans call for the setting up of one residential treatment centre for 150 patients, two therapeutic communities, at least five regional clinics, and a number of community clinics. The program will be run by the Alcohol and Drug Commission and is geared to handle 2,500 addicts. The estimated cost is $12 million a year.

Mr McClelland said a federal-provincial strategy committee has been working closely with those developing the program, and negotiations are underway concerning a cost-sharing scheme between BC and Ottawa. Federal participation is likely, he said, if addicts involved in the criminal justice system are diverted into BC's treatment program.

Under the Heroin Treatment Act, where a peace officer believes on reasonable grounds that a person has a dependency on a narcotic, he can give that person a notice requiring him to appear at an area coordinating centre and submit to a medical and psychological examination.

Dependency is defined as a state of psychic or physical dependence or both on a narcotic following its use on a periodic or continuous basis. Narcotic includes heroin and other derivatives of opium, opium, methadone, any substance with "morphine-like properties," and anything that contains any of these substances.

The examination is conducted by an evaluation panel consisting of at least two medical practitioners and one other person. The panel can detain the person for 72 hours, but within 60 hours must submit a report to the director of the area coordinating centre stating whether in its unanimous opinion the person is in need of treatment and, if so, to make recommendations concerning treatment.

If the panel is unanimous that the person is in need of treatment, the director must commit him or her. The treatment program must last for three years but the director has some options. He can direct that the person be detained in a treatment centre for six months; that the person attend at a treatment clinic at such times and over such periods, not exceeding one year in total, as the director may require; or order supervision and direction of such kind and of such duration as he may require.

The director can also apply to a board of review, consisting of at least one medical practitioner and two other persons, to have the person's six-month's confinement or one year's attendance at a clinic extended. A person committed for treatment can appeal the panel's decision to the provincial court.

John Russell, a commissioner of the Alcohol and Drug Commission, told **The Journal** no more than 5% of the people in the program would be placed in detention. The drug-free treatment programs will place a heavy emphasis on community involvement, he said, and will include behavior counselling, behavior modification, job and life skill training, and family counselling.

He added that the three year period was decided upon to provide a very strong component of aftercare and followup. "This will give us the opportunity to provide guidance for the addict over a long enough period of time to have him develop new attitudes, skills, and motivations."

Mr Russell said many people committed for treatment might appeal that decision, at least in the early stages of the program. However, once the courts have ruled on a few appeals, he expects this will taper off.

Mr. McClelland agrees. "It will be the street-wise people who will appeal, and who won't answer a notice to appear for an evaluation. But I don't expect a big problem," he said. "The people we're interested in are those that are recently addicted and who haven't become so entrenched in the drug subculture that they can't be helped."

The government and the Alcohol and Drug Commission see the program as a method of treating and rehabilitating British Columbia's estimated 7,000 to 10,000 addicts. Others disagree.

The BC Bar Association believes the Heroin Treatment Act strikes at the fundamental concepts of our society, access to due process of law, and the principles of natural justice.

Association president, Bryan Williams said the BC lawyers commend the government for searching for innovative ways to solve the problem of heroin addiction and that they do not pretend to comment on what method of treatment should be adopted.

'The bill would deprive a citizen of his civil rights . . .'

"But, we will not stand back and allow a bill to be put forth without our comment and criticism which would deprive the citizen of his civil rights, which would not allow him due process and access to law, and which would deprive him of the principles of natural justice."

Stephen Gill, who presented a critique of the legislation to the bar association's meeting in Penticton, said the bill was tabled without prior consultation with the BC branch of the Canadian Bar Association "notwithstanding that we had asked for the opportunity to review and comment upon this very important matter.

"This legislation allows the incarceration of individuals without trial, without representation, and in its widest sense will permit the medical treatment of individuals without representation — medical, legal, or otherwise — once they are in the program," he said.

In their critique of the legislation, the BC lawyers claim two of its fundamental characteristics are that it involves compulsion and the potential confinement of citizens by the state without an offence being committed; and confinement being imposed without due process of law.

"As governments enact regulatory legislation, with its attendant administrative tribunals and bureaucracies, limitations have been placed upon the extent of the application of due process of law. However, to date none of these pieces of legislation have given their tribunals powers of confinement of the person. Penalties for non-compliance have always required conviction in a court of law before sanctions affecting the liberty of the person can be imposed. Under Bill 18, the initial power to confine has in fact been delegated to the administrative tribunal."

The lawyers also question the validity of the health and treatment philosophy in the legislation.

They point out that peace officers, because of their training, may be well qualified to form a belief based on reasonable grounds that a person has committed a crime, but "we have no such confidence that they have the training to form an opinion, on reasonable grounds, that a person has a physical or psychic dependency on a narcotic."

The only requirement regarding the make up of the evaluation panel is that it consist of two medical practitioners and one other member.

"There is no requirement that the evaluation panel have an individual trained or skilled in psychological or psychiatric assessment. What is the function of the 'other member'?" The Act provides that the panel's decision is merely whether the person is in need of treatment. The CBA is concerned that there is no onus on the panel or director to establish that, in fact, they can provide a proven and effective treatment regimen.

In the lawyers' view, a curious aspect of the board of review is that there need only be one medical practitioner on the three-man board while the evaluation panel requires two medical practitioners.

"Since the issue to be determined by the board of review is not whether a person needs treatment, but what form that treatment shall take, it appears odd that the medical input is decreased rather than increased at this stage."

The requirement of a minimum treatment program of three consecutive years is also suspect. "A minimum period of treatment makes no provision for individual responses to treatment as does legitimate health legislation," says the lawyers' critique.

"We submit that the minimum period is more consistent with a concept of a punitive 'sentence' than with a therapeutic recovery period. Further, the Bill is silent about what happens to the 'patient' who is not 'cured' within three years. Is he subject to a never-ending cycle of notices and three-year treatment periods? Further, the type of treatment appears to be determined by the director of the area coordinating centre, rather than by the therapists involved in treatment."

British Columbia's doctors also doubt that the compulsory treatment program is aimed at solving a health matter. In fact, they want no doctors on the evaluation panels.

Kenneth Varnum, chairman of the British Columbia Medical Association's drug dependency committee, said if doctors sit on the assessment panel they become judges in determining whether a person should have compulsory treatment.

"This is far from their traditional role and their rapport with patients in which they advise, consult, and seek cooperation during diagnosis and treatment."

Doctors will become judges, determining who should have compulsory treatment.

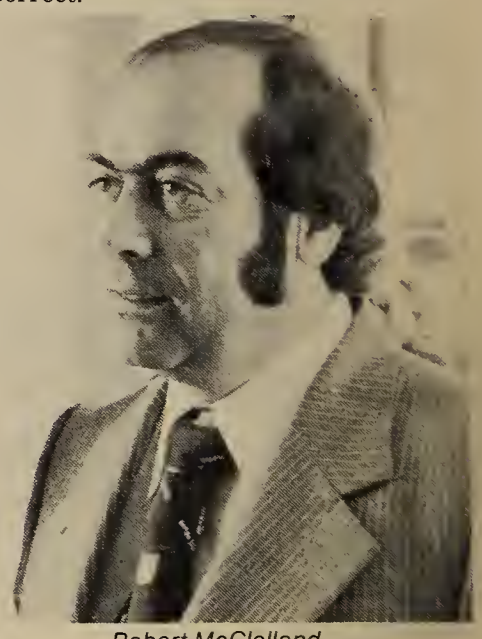
Dr Varnum said the BCMA's initial approaches to the Alcohol and Drug Commission concerning the program "were ignored" but the commission made a presentation to the association in mid-January and the general proposals were discussed by the association.

"They looked pretty good and we agreed in principle with the program," said Dr Varnum. "Then details of the legislation and the regulations came out and it became evident they were not the sort of thing we were looking at (earlier)."

Now the BCMA is of the opinion that "Bill 18 does not deal with what is primarily a health problem, but deals with a social and legal problem which has minimal medical implications." The drug dependency committee sees the presence of two physicians on the assessment panel as irrelevant, and the association's board of directors has passed a resolution urging the government to remove this requirement from the legislation.

Such a change is unlikely however. Health Minister McClelland insists doctors will be represented on the evaluation panels. He said he'd discuss the issue with the BCMA but added: "There will be medical representation. Of course there will be."

Mr McClelland thinks too that the criticisms of the BC Bar Association are incorrect.



Robert McClelland

"We have been very careful to make sure that due process is followed," he said. "Our legislation closely parallels other treatment legislation which is in place now and, in fact, goes further in protecting civil liberties than some other Acts. For example, the Mental Health Act allows for the committal of a person into a mental institution with far less provision for protection for the patient than we've built into this legislation."

Mr McClelland anticipates some problems, such as heroin addicts transfering their dependency to other drugs. But he is confident the program will work.

"I haven't been predicting success rates and I don't intend to. We think the program will work. We've seen other programs, some of which we'll be adopting, claiming success rates up to 75% and 80%. We've seen our own voluntary program with some very high success rates for the people who stayed in it.

"I think the addicts will welcome the chance to get some meaningful treatment. Some people are worried about addicts running all over Canada rather than stay in this province and get involved in treatment, but I doubt that that will happen. People come to BC, they don't leave it.

"More importantly, many of the addicts I've talked to, even those opposed to the program, have expressed a concern about their lifestyle. Many times I've heard them say if there'd been something like this available 20 years ago, maybe they wouldn't have gone through what they had.

"I don't intend to pour money down a bottomless hole. We'll admit failure if we fail, but I don't think we will," said Mr McClelland. "We consider this to be a five-year demonstration project, and if we find out at the end of that time that the program isn't working, we'll scrap it and do something different."

A sophisticated monitoring system is being built into the program. Mr McClelland insists that data obtained will be strictly confidential.

"There's no possibility of releasing information gained during evaluation or treatment to anyone. The only information that will be available to police is the name of an addict and whether or not that addict is in our treatment program."

The program will be scrapped in five years if it isn't working.

Section 19 of the Heroin Treatment Act provides that: "The commission, its members, and employees, and persons engaged in the administration of this Act, may disclose information respecting a person (a) where the disclosure is necessary for the administration of this Act, or (b) where the disclosure is to a peace officer and consists of information that may assist in the identification of the person and show whether and if so for how long, he is subject to treatment or confinement under this Act."

Vol. 7 No. 8

TORONTO August 1, 1978

PERIODICALS READING ROOM
Humanities & Social Sciences

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

Dr Bourne's exit a blow to field

By Harvey McConnell

WASHINGTON — Peter Bourne's departure as President Jimmy Carter's special advisor on health issues will reverberate through the substance abuse field and beyond.

Dr Bourne, a psychiatrist, resigned after it was revealed he wrote for an aide a prescription for 15 methaqualone tablets. He used a pseudonym instead of the aide's real name, to protect her confidentiality — a burning issue in psychiatric practice.

While in office, Dr Bourne was considered progressive, humane, and an innovator. He pushed for answers to controversial questions, such as whether marijuana and heroin have any real therapeutic use.

On a much wider front, he was a leading proponent of a liberal national health insurance bill. President Carter is now considering what sort of bill to send to Congress and powerful, budget-conscious voices in his administration are pushing a truncated version.

Because Dr Bourne is such a long-standing friend of the President, and he remained in essentially the same position, Congress allowed the Office of Drug Abuse Policy (ODAP) to expire in May. Concerned legislators will undoubtedly now consider introducing a bill which will create something akin to the defunct agency.

Reaction to Dr Bourne's resignation was swift and sympathetic by many medical colleagues.

Lionel Solursh, one of Canada's leading psychiatrists, told **The Journal**: "It is a real loss. I think many of us who have known Dr Bourne are aware of his role down there and are going to miss him. I think it is a loss to the US,, and in some ways a loss to Canada, because they influence us directly or indirectly."

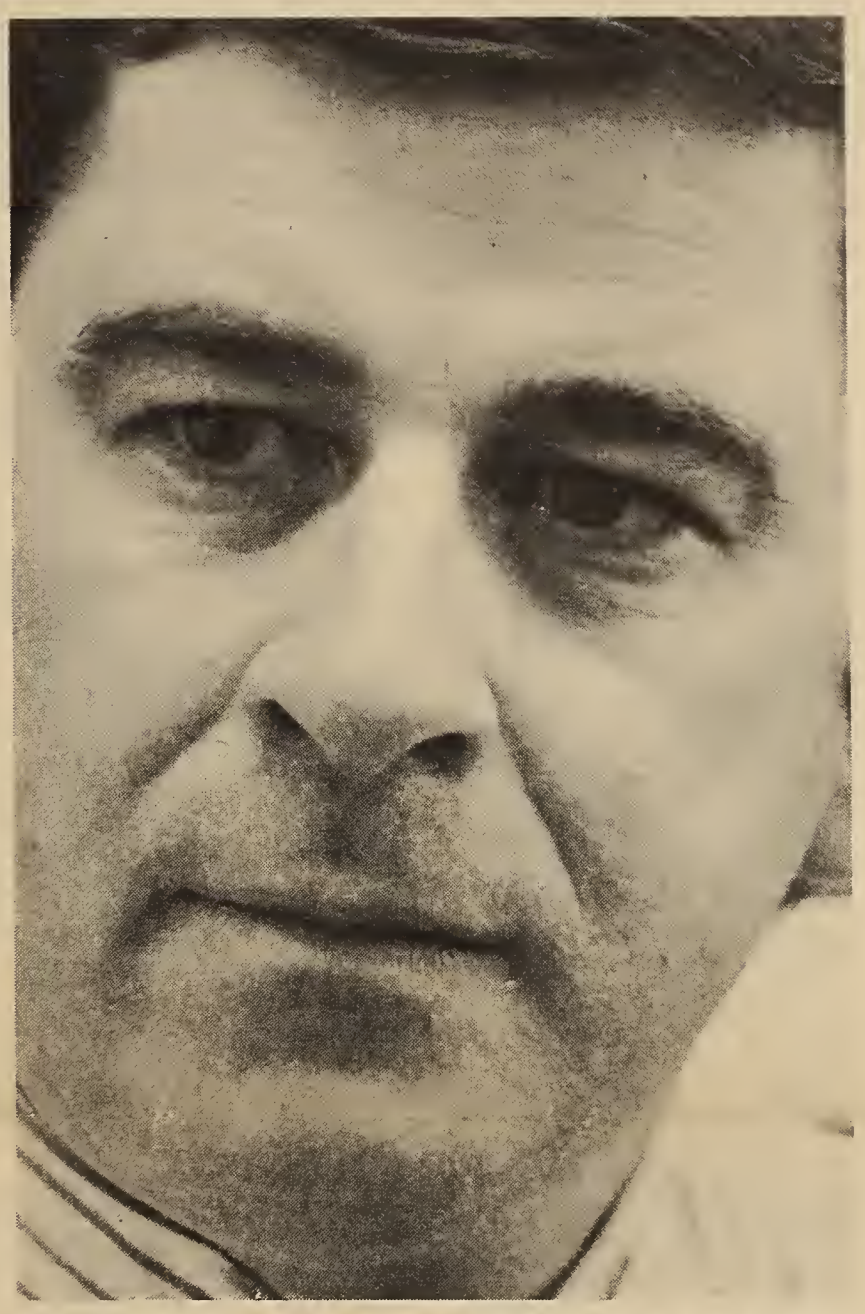
Dr Solursh, associate head of psychiatry, Toronto Western Hospital, added: "I sympathize entirely with Dr Bourne. I seem to run into these sorts of things all the time."

Following his departure, Dr Bourne told the *New York Times* that there was "a high incidence" of marijuana use, and some cocaine use, among White House staff members.

President Carter immediately issued a memo to his senior staff telling them he expected "every member of the staff to obey the law. Whether you agree with the law or whether or not others obey the law is totally irrelevant.

"You will obey it or you will seek employment elsewhere.

"I expect that you will convey my feelings directly and in no uncertain terms to every member of your staff."



Peter Bourne, whose resignation is "a loss to the United States and in some ways to Canada."

Women's alcoholism increase inevitable

By Anne MacLennan

ZURICH — The gradual erosion of the double standards applied to women and men by society will probably make alcoholics of more women in future, says Max M. Glatt.

Paradoxically, however, it will probably also improve the chances of many alcoholic women for recovery, the noted British psychiatrist contends.

• *Women alcoholics need separate research thrust.* 5.

"On the one hand, with women gradually moving out of the home and, in the business and professional world, assuming roles and rights similar to men's, they may also expose themselves to extra responsibilities and anxieties, as well as to temptations," Dr Glatt told a meeting here.

This, as well as the finding that younger and younger girls in increasing numbers are drinking, makes it likely that the number of female alcoholics will probably continue to increase, he said.

"On the other hand, with increasing acceptance of public drinking by women, probably an increasing proportion of relatively stable women may, by habitual drinking, expose themselves to the risk of . . . becoming dependent on alcohol, mainly as a consequence of habitual heavy drinking."

In the past, he said, because of the harshness of society's attitudes to females who were heavy drinkers, it may have been "in the main emotionally unstable women or those with abnormal environmental stresses (who) exposed themselves.

"The likely higher proportion of relatively stable personalities among the higher numbers of female alcoholics in future may consequently mean a relatively better prognosis for the hypothetical average female alcoholic of the future."

Dr Glatt was speaking to the 24th International Institute on the Prevention and Treatment of Alcoholism.

After investigation by The Journal

File #14086 finally prised open

By Bryne Carruthers

OTTAWA — Federal Health Minister Monique Begin has decided to reverse an earlier federal cabinet decision and allow Canadians to find out most, though not necessarily all, of what the federal Bureau of Dangerous Drugs has in its secret and controversial data bank on more than 200,000 known and suspected drugs users and distributors.

Instead of being totally secret, as health department bureaucrats had rationalized was both legal and warranted, the drug files will soon be open to inspection by named individuals, subject to necessary restrictions on access to information on third parties, or on release of information that could jeopardize ongoing criminal investigations.

Health Minister Begin says she has "the simple conviction that a more direct ministerial control and a case-by-case review (where warranted) of what information should not be released, is the best way to protect individual rights."

Responsive

In effect, Health Minister Begin feels that an elected politician is more responsive to individual needs than bureaucrats — an interesting conviction, since the minister took only one month to decide to reverse what the department's bureaucrats took six months claiming could not be changed.

The important ministerial decision was announced within days of the publication last month (and the ensuing publicity) of another in a series of articles in **The Journal**. The articles were on the circumstances leading up to the complete exemption of federal Bureau of Dangerous Drugs file number 14086 (drug users and distributors) from public scrutiny under the Human Rights Act.

Necessary

In that article, Health Minister Begin had announced she was launching an internal investigation (as a direct result of enquiries by **The Journal**) to determine how the files came to be kept totally secret and whether and how they could be opened

The latest decision means that secret files on one of every 100 Canadians will soon be available for viewing and challenge by the named individuals, as provided under the Human Rights Act.

Ms Begin's decision also comes despite vigorous private protests by some of the police forces (notably the metro forces in Vancouver and Toronto) that supply much of the information contained in the drug files. Police had expressed concerns that opening the files could jeopardize some of their sources of information on drug crimes.

Ms Begin says the necessary amending cabinet order will be passed by mid-August

She adds the new cabinet order will provide the health minister with the discretionary power to delete sensitive information from a file before it is shown to the named individual.

For example, to protect the privacy of others, references to third persons would likely be deleted, along with information that might jeopardize ongoing criminal investigations, or even national security.

However, under the Human Rights Act, the named individual has to be informed that some information has been deleted from the file. The individual will also have the right of appeal to the Privacy Commissioner if the individual feels the health minister is withholding information that should be available.

(See — Decision — page 5)

NDAC '79 in jeopardy

WASHINGTON — Several organizations and individuals have decided not to take part in the National Drug Abuse Conference scheduled to be held in New Orleans in September, 1979.

Representatives of therapeutic communities have decided to boycott the conference and Ron Gaetano has resigned as region two national co-chairperson.

As of July 10, a promised $75,000 from Louisiana officials had not been deposited into an NDAC bank account as promised

A motion was passed by delegates at the Seattle conference not to hold the meeting in Louisiana because the state has not ratified the Equal Rights Amendment (ERA)

The National Association of Puerto Rican Drug Abuse Programs has voted to boycott the conference because of the ERA issue and scheduled a substance abuse conference in San Juan in June, 1979.

Police, stress, and alcohol. p. 6.

Doctors as the addicted. p.16.

A researcher remembers. p. 9.

Regular features

• *Wayne Howell* 2
• *Letters to Editor* 8
• *New Books* 14
• *Coming Events* 15

Plans for legalization

Heroin addicts are medical 'scapegoats'

By John Braddock

VANCOUVER — Heroin addicts are the "medical and political scapegoats" of our time, Thomas Szasz, the controversial psychiatrist and psychoanalyst at New York University, has told more than 100 opponents of the proposed compulsory treatment of heroin addicts in British Columbia.



Thomas Szasz

Dr Szasz, whose latest book is *Ceremonial Chemistry: The Ritual Persecution of Drugs, Addicts and Pushers*, said society apparently needs to look down on certain subsections. And in the 70 years from the end of the last century these groups have included epileptics, orphans, and lepers, amongst others.

He bitterly criticized the legislation in BC for the compulsory treatment of heroin addicts, either in community clinics or during confinement in an institution.

He claimed the legislation is not only dictatorial and discriminatory but based also on a false premise that heroin addiction is a disease which can be treated.

He said heroin "addiction" merely means the habit of taking heroin. And it's no more a disease than the taking of alcohol or the smoking of cigarettes. The outcome may be physiologically undesirable — but physiological harm can come from dangerous sports or even life itself.

However, he disagreed heroin is, in fact, either immediately habit-forming or causes physical or psychological harm. "It's singularly clean."

Dr Szasz was speaking at a June meeting in nearby Richmond, arranged by The Ad Hoc Committee On The Compulsory Addiction Treatment Plan.

Heroin doesn't cause crime; prohibition does, he said. The trouble arises when users seek money to pay for the high cost of the drug on the black market.

Although at times it appeared Dr Szasz and other speakers were advocating heroin, they were in fact making a plea for the legalization of the drug to remove it from the black market and associated crime.

Peter Stein, former chairman of the BC Alcohol and Drug Commission under the previous New Democratic Party government, said he has little personal sympathy with heroin users — he gets his own highs by fasting or jogging — but recognizes a certain number will always exist, and a certain number of those will need help.

He said the commission in his time was working on voluntary clinics so that, "in the words of the businessmen so loved by the present (Social Credit) government" in BC, they could "minimize the loss and damage" to society.

Mr Stein said he's since reluctantly come to the conclusion that a compulsory program is now historically necessary for BC to work through — "the only way the hysteria, the irrationality, the inhumanity may move into new levels of insight" — although in his opinion "it has no possible likelihood of working."

Dr Guy Richmond, who has had more than 20 years of experience as a medical officer in correction institutes "and has dealt with thousands of heroin addicts," nevertheless said the decision of a user to stop seems to have no bearing on attempted treatment.

"It comes out of the blue, unpredictably, a spontaneous, free act on the part of the user . . . it happens in spite of us."

John Conroy, a member of the committee of the BC Bar Association that presented a critique on the proposed legislation to provincial Health Minister Bob McClelland, picked holes in the legislation as now drafted. He called it "very sloppy indeed."

In particular, he was concerned about the lack of the due process of law in administration of compulsory treatment, the "confused roles" for police and doctors, the possibility of untreatables going round and round through the system, "and who run the risk in effect of a life sentence", and inadequate appeal procedures.

To Donald Sorochan, president of the BC Corrections Association, compulsory treatment is abhorrent because it will frighten off those looking for assistance without commitment. He said his association recommends a trial period of different forms of treatment through voluntary programs.

And Don Brown of the BC Civil Liberties Association said the mere fact libertarians are organized in protest "is a good sign something is wrong in civil politics."



Peter Stein

Besterman new NIDA chief



Robert DuPont

WASHINGTON — Karst Besterman has been appointed acting director of the National Institute on Drug Abuse (NIDA), replacing Robert DuPont, who resigned to join a major American television network.

Mr Besterman had been NIDA deputy director for a number of years under Dr DuPont. Within a week of leaving NIDA, Dr DuPont appeared on television in his new role as health consultant to the ABC network program AM America.

BC commission given six months to prepare addict treatment rules

VANCOUVER — After inserting a number of last-minute amendments, the Social Credit government here managed to push through third reading its controversial Bill 18 on compulsory treatment of heroin addicts.

The main opposition party, the New Democrats, still voted against the Bill — Opposition Leader Dave Barrett called it unworkable — but the changes were sufficient to win the support of Liberal Leader Gordon Gibson. Progressive Conservative Leader (and only PC member)Vic Stephens was absent. Consequently Bill 18 passed by 29 to 16.

The British Columbia Alcohol and Drug Commission now has about six months to prepare regulations in keeping with the Bill, obtain buildings, and hire about 400 additional staff members.

The amendments came suddenly at the end of the second reading, following a rising tide of criticism from lawyers, doctors, and civil rights groups. And the weekend before, a combined group of dissidents called The Ad Hoc Committee On The Compulsory Addiction Treatment Plan held a public information forum in Richmond, on the outskirts of Vancouver.

The main amendment introduced by Health Minister Bob McClelland affects addicts who don't consent to treatment. Instead of the director of an evaluation panel directing them into a specific form of treatment, they will go first before a judge of the BC Supreme Court to decide if the evaluation is justified.

This change spiked the guns of many opponents objecting to the lack in the previous wording of the Bill to due process of law.

Mr McClelland seemed to have the doctors in mind also. Previously the BC Medical Association waxed hot and cold. It agreed in principle that heroin addicts should be assisted but it grew concerned over the details. Dr Kenneth Varnum, chairman of the BCMAs drug dependency committee, said doctors are unhappy with playing the role of judges if they sit on the evaluation panel. And the legislation specifies two physicians be on the panel. But doctors probably would not object to acting as consultants.

In the amendments Mr McClelland still specifies two doctors on the panel but gives them greater scope in defining or interpreting their roles. The changes say it is not necessary for all panel members personally to examine an individual, or all be present at the same time. "And in forming their opinion and making their reports and recommendations they may rely on analyses and tests carried out at the direction of a member of the evaluation panel or by an employee of the (Alcohol and Drug) Commission or another group."

To this Alice-in-Wonderland situation, Stephen Gill of the BC Bar Association's committee on Bill 18 commented: "The new examination procedure does not require all members of the valuation panel to personally examine a patient. How can a proper medical and psychological examination be done in the circumstances?"

The BC Bar Association takes the position that while much of the change goes a long way to meeting its objections about the lack of due process of law, none of the amendments has altered the basic question as to whether the new legislation is constitutional.

Sociologists the clue to outer space invaders

By Wayne Howell



Reputable archaeologists and anthropologists had little trouble debunking *Chariots of the Gods*, the Erich von Daniken book that claimed extraterrestial visitors to earth were responsible for many of the achievements of ancient civilizations. However, *Mind Invaders from Outer Space*, von Daniken's latest book, cannot be so easily dismissed because unlike *Chariots of the Gods* which attempted to convince with dubious facts, spurious logic, and rhetorical question, *Mind Invaders* proceeds much more logically to its rather startling conclusion.

According to von Daniken, he first became suspicious that something strange was going on when he attended a social science seminar and heard a normal appearing psychologist speak of a treatment program being "targetted" at a particular group of individuals. The ostensibly normal professionals and para-professionals in the audience appeared to accept this with equanimity.

At first von Daniken searched for a simple explanation; perhaps this was simply a human error — the speaker was not quite awake at 9:30 am. But this proved not to be the case: von Daniken's investigation revealed that not only had the speaker used the word in question many times before in oral presentations, he had used it in written presentations as well. In spite of this rather remarkable finding, von Daniken was still not alarmed — after all, there is no law against idiosyncracy. And surely the non-reaction of the listeners could be explained by the fact that they had not heard correctly. However, investigation showed that not only had the social scientists in the audience heard the speaker perfectly well, they professed to find nothing strange about "targetting" since they used the term frequently themselves.

By now von Daniken was genuinely alarmed. What was going on? By various subterfuges he managed to get the aforementioned conference speaker to accompany him to an archery range.

"What are you doing," von Daniken asked as casually as possible as he watched the speaker draw the bow and aim at the bullseye. The speaker turned his cold blue eyes upon von Daniken.

"I'm targetting my arrow," he said. Von Daniken felt a strange tingling sensation at the back of his neck.

Von Daniken's next step was to consult with various experts.

"Why would a person replace the perfectly legitimate verb *to aim* with the bastardized verb *to target*?" he asked.

"Lack of an elementary school education could be the cause," they replied.

"But these people all possess college degrees and many of them posess advanced degrees," said von Daniken.

"In that case, perhaps it is just intellectual sloppiness," replied the experts.

"But these people are not intellectually sloppy; their scientific and administrative work shows they are generally careful, methodical, and precise," said von Daniken.

"In that case, perhaps their minds have been bent or twisted by chemicals of some kind and now they simply lack the motivation to speak correctly," said the experts.

"That cannot be," said von Daniken, "for most of these persons are opposed to self-indulgent drug use and work actively to discourage it."

"In that case," said the experts, "then we can think of no earthly reason why they would do such a thing."

"What you are saying then," said von Daniken, feeling once again that strange tingling sensation at the back of his neck, "is that the verb *to target* fulfills no human need."

"That is correct," said the experts.

Twelve months later, von Daniken's *Mind Invaders from Outer Space* hit the bookstores with its sensational theory that extraterrestial visitors were secretly taking over the minds of social scientists, rendering them incapable of speaking proper English. Under the circumstances, as von Daniken explained, it was the only rational explanation.

(Wayne Howell is an Ottawa physician and freelance writer.)

Sin won't sell alcoholism prevention

By Anne MacLennan

ZURICH — Alcoholism prevention messages are going to have to get "a lot more personal" if people are going to listen, says Ernest Noble.

"We have to talk about things that matter to people who are in specific life situations," he urged the 24th International Institute on the Prevention and Treatment of Alcoholism. Dr Noble is former director of the United States National Institute on Alcohol Abuse and Alcoholism.

He said the old idea "that you changed people's attitudes by preaching about the demon rum and how sinful it is" doesn't work in contemporary America.

"Sin has never been all that unpopular anyhow."

If sin and statistics don't work, what will? Getting personal and explicit, he said.

"If people are to make personal



Ernest Noble

choices about how much to drink — or whether to drink at all — they need informed opinion to help them. That's our job.

"We know something about the risk factors but not nearly enough. . . . We need to know more about people in specific life situations. There are countless situations, including genetic, biological, and metabolic differences that bear on how much alcohol a given person can consume without introducing a risk."

For a recovered alcoholic, he said, risk begins after zero drinks. For a pregnant woman, two drinks or less per day have been recommended.

The risk is greater to drink and drive than to drink and watch television. People under stress, or in a state of depression, are at a greater risk level than people who are not undergoing emotional or situation trauma.

He said the alcoholism prevention field is "where the cardiovascular research field was several decades ago. They did not know the risk factors then. Today, there are known risk factors and physicians are in a better position to advise their patients."

As a result, people can make informed personal decisions about their personal habits as they relate to heart disease, he said.

"We need a similar body of knowledge and, as we learn what these factors are, we need to communicate them to people. Based on this knowledge, they may then adopt the quality of life they wish to choose."

Smokers can cause angina in others

BOSTON — Angina (chest pains) can be induced in cardiac patients if they sit in a room near someone who is smoking a cigarette.

William Aronow, who directed the study at the Veterans Administration Hospital, Long Beach, California, found also the 10 men tested could not exercise as long as usual and some developed a premature ventricular (irregular) heart beat.

Dr Aronow, in his report in the *New England Journal of Medicine* (May 6), said tests were carried out with men who had suffered angina in the past. They were put into a room measuring 11 x 12 feet with three men who each smoked five cigarettes.

The patients could exercise for at least four minutes before experiencing chest pains previously. This fell to an average of 2½ minutes after they had breathed the cigarette smoke.

Dr Aronow said the cigarette smoke caused heart rates to increase, blood pressure to rise, and in three men produced premature ventricular heart beats.

Dr Arnow said breathing the smoke of others is still not as bad as smoking directly. However, carbon monoxide in the smoke decreases the amount of oxygen in the blood while the nicotine increase the demand for oxygen.

Recent literature shows:

Alcoholics' cancer risk is +30%

ZURICH — Many people in the health care field do not realize the risk of developing cancer is increased significantly among heavy drinkers.

A review of recent literature shows the overall frequency of cancer in alcoholics is approximately 30% higher than normal, according to A. B. Lowenfels, associate director of surgery, Westchester County Medical Center, Valhalla, NY.

Dr Lowenfels, in a report to the 24th International Institute on the Prevention and Treatment of Alcoholism here, said there are a number of ways alcohol may contribute to an increased incidence of cancer.

It is possible alcohol itself is carcinogenic, although "to date there is no convincing evidence that pure alcohol is carcinogenic either in animals or man."

Alcohol could damage a particular organ and enhance the carcinogenic action of cigarette smoke. Most alcoholics are heavy smokers.

The additives used in alcohol, as well as production methods and storage, might produce a carcinogenic effect, Dr Lowenfels said.

Nutritional deficiencies associated with alcoholism might be implicated: for example, many alcoholics are deficient in vitamin A, which protects mucous membranes against proven carcinogens.

Dr Lowenfels said alcohol could act as an unsuspected carcinogen in the diet. Another possibility is that alcohol induces hormonal changes.

Dr Lowenfels said: "It is impossible to be sure which of these hypotheses is correct.

"The problem is especially difficult because most alcoholics are heavy smokers and many are also malnourished."

Dr Lowenfels said most alcoholics overlook early warning signs of cancer and often a tumor has reached an advanced stage before they seek help.

"To effect a lasting cure is unusual and, in our experience, overall survival rates are diminished in alcoholic patients with cancer." In addition, most alcoholics do not report for necessary frequent followups.

Dr Lowenfels said research is needed to determine the carcinogenic potential of alcohol in the absence of smoking and whether alcohol penetrates the placental barrier to act as a carcinogen for the fetus.

On-job treatment best for alcoholic workers

By John Shaughnessy

TORONTO — The workplace is the best climate to bring alcoholism under control, says Gordon Patrick, an expert in employee assistance programs.

This is true, he says, because studies over the last decade have shown most alcoholics are employed; that alcoholics who are coerced into treatment respond as well as those who enter voluntarily; and that the employer is the most important person in motivating a problem drinker to seek help for his or her dependency.

Mr Patrick, president of Gordon Patrick Associates, and formerly a staff member of the Addiction Research Foundation of Ontario, told the first annual Donwood Conference here that in 1958 Ontario had about 85,000 active cases of alcoholism; in 1965 the figure was 108,000 and in 1977 about 160,000.

"In 1958, something less than 5% of these people were getting any form of treatment at all, and the majority of those that were were getting it through Alcoholics Anonymous," he said. "Twenty years later, fewer than 10% are receiving any kind of treatment and again more than 75% of the people receiving treatment are getting it through AA."

According to Mr Patrick, in public health terms there is clear evidence that "secondary and tertiary" prevention focusing in the workplace can be effective, and there is reason to be optimistic that primary prevention may be possible.

"We believe there is real evidence that the workplace offers the best climate to bring alcoholism as a public health problem under control. Our experience, however, indicates the need for the employer to integrate an employee alcohol-drug misuse program into all areas of the organization."

John Caldwell, an associate of Mr Patrick, said the key to bringing this public health problem under control in the workplace is simply "good management."

Normally, good management and good union practice are therapeutic, said Mr Caldwell, "If a person is sick or injured in the workplace, the supervisor and union steward work together to get that person the help he or she needs, and there are procedures that can be set in motion immediately.

"However, when everyone knows there is an alcohol or drug problem behind a worker's illness and poor job performance, good management practices are abandoned and forgotten because of some taboo we have in our mind, particularly about alcohol. If supervisors and union stewards would stop this very apparent cover up and bring the dependent person to treatment earlier, we know that person's hope of keeping his job and recovering his health is increased four or five times."

Mr Caldwell said management and unions can be convineed of the merits of this approach if two things are stressed. "First, you are not setting up a confrontation between management and the problem drinker. The confrontation is between the problem drinker and the realities which he has been missing or escaping because of the misuse of alcohol."

Second, supervisors and union stewards are not asked to become experts on alcoholism and drug abuse. "They are not providing treatment. What they need to know and recognize are the very visible warning signs that a problem is beginning or is present."

The distaste of some supervisors and union stewards for "sticking their nose into other people's business" is misplaced, according to Mr Caldwell.

"If I was a supervisor and I had a problem drinker under me who was not doing his job, I'd worry about my problem as a supervisor.

"If the problem drinker is one of those exceptions that 'performs well' on the job, the supervisor has no right or need to speak to him. But the union man has every right to speak to him as a brother. He can say, 'Look, we know you've got a drinking problem outside of work. We've got a program here, and it will be better for you to go and take treatment now before you're required to take it.'"

New rat model aids brain study

COLUMBIA, MO — A new experimental model may aid in preventing or reversing brain damage in alcoholics.

Ezio Moscatelli and George Amromin, University of Missouri School of Medicine at Columbia, were able to induce alcoholic brain damage in rats — a difficult task up to this time because the animals don't like to drink great quantities of alcohol.

Drs Moscatelli and Amromin simply added enough alcohol to a glucose solution to duplicate the concentration in a heavy, 160-gram-a-day drinker's diet, for half the experimental group. The other half received no alcohol.

Fifty percent from each group were fed diets high in thiamin and protein, and the rest were fed diets low in those nutrients, which are frequently missing in the alcoholic's diet.

After four months (which equalled 10 to 12 years of heavy drinking in humans), the rats' brains were removed and studied.

Pathological changes were seen in all groups except for the high-nutrient, non-alcoholic group. The greatest damage was found in the brains of alcoholic rats on low-nutrient diets. But Drs Moscatelli and Amromin said the alcoholic rats on the high nutrient diet also suffered brain damage, which illustrates alcohol itself can produce brain damage without the aid of poor nutrition.

Dr Moscatelli says this inexpensive experimental animal model will enable him and Dr Amromin to study possible enzyme involvement in the destruction of myelin (the substance surrounding nerve fibres). They wish also to use this model to study disease-induced brain damage, as found in multiple sclerosis.

Drs Moscatelli and Amromin presented their findings to the Federation of American Societies for Experimental Biology.

Lawyers want pot revision

TORONTO — Criminal lawyers in Ontario want the federal government to relax its marijuana laws.

The Ontario Criminal Lawyers Association said recently (June 29) laws dealing with possession and cultivation of cannabis for personal use should be transferred to the federal Food and Drug Act from the Narcotic Control Act.

In their statement, the lawyers said also the federal government should lift the statutory minimum sentence of seven years for a person convicted of importing marijuana under the narcotic laws because of the harmful effects prison has on the young first offender.

J878

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A federal retreat on pot

OSHAWA, ONT — A federal government medical expert has conceded marijuana is not a narcotic, although "it is a dangerous drug."

Thomas DaSilva, head of the government's Health Protection Branch, described marijuana as a mild hallucinogenic that could disturb or impair the body's control systems. Testifying at the trial here of Michael Taylor Of Toronto, who is charged with possession of marijuana, Dr DaSilva said: "It's certainly a dangerous drug."

Defence lawyer Edmund Brown, a member of NORML (Canada) — the National Organization for the Reform of Marijuana Laws — considers the trial a test case of marijuana's status under the Narcotic Control Act. He is arguing that marijuana is wrongly classified under that Act and should instead be under the Food and Drug Act which has less severe penalties and does not make simple possession a crime.

T. Reid McKim, director of the federal Bureau of Dangerous Drugs, testified his bureau doesn't consider marijuana a narcotic in a pharmacological, medical, or chemical sense. But, he said the bureau still regards it legally as a narcotic.

Dr DaSilva said tests on marijuana have not conclusively established the potential effects of long term use of the drug. He said studies in Jamaica and Costa Rica that showed marijuana smokers suffer no long term mental and physical effects might not necessarily apply in Canada.

He also rejected Mr Brown's claim that marijuana has numerous medical uses. Dr DaSilva said that while it was used medically at the turn of the century, there are now "no accepted medical uses." Later he conceded that marijuana is being considered in the treatment of nausea and vomiting associated with chemotherapy in cancer patients.

The trial, which began in January, resumes in late August.

New smoking alert for heart patients

WASHINGTON — Post coronary care patients who continue to smoke run an extremely high risk of a second, and fatal, infarction.

This is one of the most significant findings yet in a long term Canadian study of whether high or low intensity exercise will benefit post-coronary patients. The study began in 1972 in seven Ontario medical centres and will continue until 1981.

John Sutton, of the cardiorespiratory unit, McMaster University, Hamilton, Ont., revealed the as yet preliminary findings following a symposium here at the annual meeting of the American College of Sports Medicine.

Dr Sutton told **The Journal** that among the 751 men enrolled in the program "almost all of the mortalities so far have been among men who have continued to smoke. We don't know yet how significant that is, but it is a trend and it has a lot of implications.

"Now I bend over backwards to try and convince my patients they really, really have to strive to give up smoking. In fact, while our patients are recovering in hospital we devote a whole evening to the question of smoking."

The Ontario study, the largest ever carried out, has tried to follow each patient admitted to the program, whether he later drops out or not, for four years. The last cohort entered in October, 1976, and will be followed until 1981 when all of the statistical data stored in computers will be analyzed.

The purpose of the study is to see if a lengthy program of exercise will, over time, decrease the chances of a second infarction. The investigators are not yet sure if it will.

Dr Sutton said the figures gathered about deaths among smokers has been something of a surprise. "But I do know that within my own unit, at least up to six months ago, every death has been of a smoker who continued the habit after leaving hospital.

"What one wants to get from a study like this are methods which are going to improve the way you manage patients. I think the highly significant data we have on smoking, even though it is preliminary, makes a doctor morally bound to emphasize more than ever the dangers of smoking."

Dr Sutton, a non smoker, is one of the principal investigators and advocates exercise for certain post coronary patients.

He has little doubt if there is a conflict in a patient between smoking and exercising. "I think I would say they should probably stop smoking."

Shamattawa success

Youth gas sniffing on the wane

By Manfred Jager

WINNIPEG — There is reason for hope that a serious and persistent gasoline sniffing problem in the northern Manitoba community of Shamattawa will be resolved in the near future.

Roger Boeckx, assistant director of clinical chemistry at Winnipeg's Health Sciences Centre told **The Journal** that about 60 children aged eight years and older have been brought to Winnipeg from Shamattawa during the past two years to receive treatment after showing lead poisoning symptoms of varying severity. (Dr Boeckx made the statement after addressing the 42nd annual convention of the Canadian Society of Laboratory Technologists on implications of lead poisoning.)

Three of the youngsters have died as a direct result of lead poisoning due to gasoline sniffing, while another five or six died from related causes, such as exposure in the extreme cold of their northern community, or in fires, after being intoxicated from sniffing gasoline.

Most of the youngsters who were brought to Winnipeg to live in foster homes while receiving long term drug therapy to flush their systems of the lead they had absorbed, have made full recoveries, Dr Boeckx said. Seventeen of the Shamattawa children remain under treatment now and will return to their communities shortly.

"There has been an awful lot of improvement right in Shamattawa and I think the problem will be resolved in the not-too-distant future," he said.

He said Chief Judah Miles of the Shamattawa Reserve has shown "strength and determination" in organizing community action to decrease both alcohol abuse by parents and gasoline sniffing by their children.

"But major credit is also due to the medical services branch of Health and Welfare Canada," Dr Boeckx said. "They have given tremendous support to the treatment programs for these people up there."

Dr Boeckx said a lot of money and effort has been put into finding solutions for what could have been serious deterioration in Shamattawa community life.

Treatment with agents which flush the lead out of victims' blood and help them excrete it through their urine takes between three and nine months.

Cannabis linked with road deaths

LONDON — A random survey conducted by scientists from the University of Surrey and the Home Office Forensic Science Laboratory has indicated cannabis may be a more significant factor in UK road accidents than has previously been realized.

Tests were carried out on the bodies of 54 motorists and 12 motorcyclists killed during a 10-month period last year and 10 were found to have been using the drug. A new technique for cannabis detection devised by the Home Office laboratory was employed.

A spokesman for the Home Office told **The Journal** that despite the small scale of the trial, the results were regarded as "alarming."

A report in the *Forensic Science Journal* says: "As more potent and intoxicating forms of cannabis are now becoming popular, all road users may need to be given cannabis checks in future.

"A much broader survey of cannabis involvement in all accidents or even among all road users should be undertaken to discover the exact extent of its use."

Later, a spokesman for the Royal Society for the Prevention of Accidents said: "If these figures are typical of what is happening there is obviously a need for urgent research. We hope the government will do something to instigate a much bigger survey. We fear it could be as big a problem as driving under the influence of alcoholic drink."

Virginians drink on feet

RICHMOND, VA — Virginians can now drink standing up at any sign of the olive in the martini glass. Everything, that is, but Billy Beer.

These are among the decisions that have been made by the state Alcoholic Beverage Control Board 10 years after it was decided liquor could be sold by the drink.

The olive in the martini glass sign can be used to identify establishments which sell alcohol. It won't be in flashing neon: the sign can be no larger than one foot square.

Bar customers will now be able to drink standing up so long as the bar capacity of 2.5 feet per person is no greater than a third of the total table space.

But there will be no Billy Beer. Under a rule that alcohol cannot be endorsed by "any prominent living person" the board banned Billy Beer sales because the brew is endorsed by President Carter's brother.

The board decided also to let brewers, but not distillers, sponsor sports events. However, any uniforms, trophies, or advertisements for the events can carry only the company, not the brand name.

Malaysian *bomohs* use ancient arts for addicts

By Richard Borsuk

KUALA LUMPUR — The 21-year-old man pulled up his shirt so the "doctor" could begin his treatment. First, using black ink and a thin brush, the doctor wrote verses in Arabic from Islam's Holy Koran all over the youth's chest.

Next, he laid the patient down and chanted in his ear, then he had him drink one small glass of a strange green liquid.

Vital role

That ended the first day of a 45-day treatment by a traditional native Malay doctor, *bomoh*, for a contemporary Malaysian problem — drug addiction.

Unscientific as the treatment may be, a number of bomohs in Malaysia claim they have devised effective methods of getting addicts off drugs. With drug abuse here growing to alarming levels, government interest in using bomohs to treat addicts has grown.

In mid-1977, the United Malay National Organization (UMNO), the dominant party in Malaysia's ruling national front, decided to promote the use of bomohs as one way of helping addicts.

When 100 homohs from throughout Malaysia met in Kuala Lumpur last August to discuss the role of traditional medicine, the possibility of using their services to treat addicts was a key topic. Since the meeting, UMNO special officer for drugs, Radin Supatan, has been locating bomohs who claim ability to treat drug cases, and referring addicts to them.

Official interest in treatment by homohs grew from awareness that other countries were experimenting with traditional or unconventional medical techniques for treating addicts. In a recent interview, Radin Supatan cited Hong Kong's ongoing experiments with acupuncture as one example.

"This isn't practised here as it is the Chinese way," he said. "But we think our traditional practices can also be used in our war against drugs."

It's a hot war, he said, since the number of users of soft and hard drugs in Malaysia has jumped from a few thousand five years ago to 200,000 today. "Drug abuse is the country's second biggest enemy after communism and the bomohs can play a vital role in defeating the enemy," he said.

So far, the effort has by necessity been small. Bomohs, like physicians, often specialize in treating certain diseases. At present, only about 10 of Malaysia's thousands of bomohs claim the competence to treat drug addicts.

One is 60-year-old Radin Suratnam, a bomoh born in Indonesia. He said he has long been concerned about Malaysia's drug problem.

Faith the key

"Three years ago I was asking Allah how to cure drug addicts and one Friday night a spirit came and told me how to do it," Radin Suratnam said.

The treatment starts with writing the Koran verses on the patient's chest. The following days involve more writing, sometimes on the patient and sometimes on sheets of paper. These pages are burned and their ashes mixed in water to make another medicine.

There are several kinds of liquid medicine: some for extracting all traces of drugs from the body, others for helping patients prevent the torture of drug withdrawal.

Radin Suratnam said the specific ingredients in the herb-based medicine were from Indonesia, but he refused to identify them. "If Western doctors recognize this as a proper way of treating addiction, I'll reveal what I use," he commented.

The bomoh said he has treated 46 addicts so far. All but two were cured after 45 days and didn't go back to drugs, he said. Patients are charged about US $20 for the medicine.

Beyond that, it's up to the patient how much he'll pay the homoh.

To outsiders, it appears faith is as important as the medicine. Emphasis is put on Islamic prayer, by both the bomoh and the patient. Radin Suratnam said faith can make the difference, adding that the two unsuccessful cases involved people who were "stubborn-headed and didn't go with the treatment." UMNO's Radin Supatan said he thought the key was "belief and the will of God."

'Green medicine'

In spite of the importance of belief in Islam, Radin Suratnam said his successful patients have included non-Muslims. When treating non-Muslims, the bomoh does not write on the patient, but the green medicine is the same, he said.

One 20-year-old Malay youth vouched for the success of Radin Suratnam's treatment. A heroin addict for three years, he said he was treated in hospital in early 1977 "but I felt worse and my craving for drugs grew." Later he tried one bomoh who asked him to drink one jug of liquid for three days, but that failed too. Then he was referred to Radin Suratnam in early November and when treatment began "I started to lose my desire for drugs right away."

Women alcoholics need separate research thrust

'No typical alcoholic'

By Anne MacLennan

ZURICH — The assumption the typical alcoholic is a man is wrong, says Max M. Glatt, a British psychiatrist who has treated thousands of female alcoholics in a variety of settings.

Female alcoholics are not only a separate group with different problems but there are probably subgroups of women as different from each other as female drinkers are from male drinkers, Dr Glatt said here.

"All over the world, there has been a relatively great rise in the proportion of female problem drinkers.

"Surely, the mere numerical size of the problem has now reached such dimensions that female alcoholics have to be approached as an independent entity and not merely as a relatively insignificant appendage to their male counterparts."

He said the claim science is male-dominated "certainly seems to apply to the subject of alcoholism and its treatment.

"Practically all the general pronouncements in this area are derived from a consideration of male drinkers and the findings rather uncritically generalized to women."

He agreed with Greenblatt and Schuckitt* that "there is scant scientific literature related to women and alcohol because the preponderance of experimental studies related to acute and chronic effects of alcohol have evaluated only male participants. Therefore, the practitioner who is interested in understanding and treating women with alcohol problems has little scientific data on which to base treatment approaches."

Dr Glatt said given the task of discussing treatment of alcoholism in women, "one finds oneself in considerable difficulties."

Based on existing literature and his own experienee over many years, he said that, like male alcoholics, "female alcoholics are (also) a very heterogeneous group.

"There is not such a person as the female alcoholic. Quite different personalities with widely varying psychological and physical make-up who have taken alcoholic drinks of varying eomposition and concentration, for different reasons, under different conditions, have become alcoholics.

"Clearly, not only may there be important differences between male and female alcoholics but, among the latter themselves, there are not only many different individual personalities but possibly subgroups so different from each other that generalizations from one to the other may be as suspect as those made from male to female alcoholics.

"As in male alcoholics, it seems extremely unlikely that one and the same treatment modality should be the best for all female alcoholics: it would seem more likely that the best approach at the present juncture should consist in assessment of the factors most significant in the given individual and then applying a combination of therapies best suited in her case."

There are some common factors at work in both male and female alcoholics, he said. However, there seem also to be important differences — psychological, social, and biological in origin — with likely implications for treatment planning.

"Of obvious implication for treatment is the common finding that habitual misuse of drugs other than alcohol seems relatively much more common in female than among male alcoholics.

'Female alcoholics are not merely an insignificant appendage to their male counterparts . . .'

"From the prophylactic angle, in view of the considerable risk of superadded drug misuse and 'other drug' dependence, especially in the case of alcoholic women, it is imperative that the doctor, especially in the case of 'vulnerable' women, be on guard and restrict the prescribing of psychoactive drugs to a minimum."

As for poorer treatment results with female patients, he said it could be argued that as a result of society's historical disdain for women who were heavy drinkers, only those under extreme pressure or seriously unstable, exposed themselves.

With an increasing number of relatively stable woman joining the ranks of those with alcoholic problems, treatment results may improve.

It could also be argued, said Dr Glatt, that "the usual finding of women alcoholics fairing worse in treatment may, in part, be due to the fact of quite inadequate research in the field of female alcoholism and the failure to try to correlate research findings as regards background, personality factors ete of women drinkers with the provision of special treatment centres geared to their special needs.

"There can of course be no doubt as to the need for research directed specially at problems particular to women alcoholics and problem drinkers, in view of the relative lack of such studies and the often conflicting results."

Among suggested differences between male and female drinkers, he noted:

- The frequency of occurrence and the age of onset of certain features have often been found to be markedly different in male and female alcoholics. Women appear to start drinking later and have a later onset of problems.
- Women appear to have a lesser incidence of 'blackouts' but, in general, more suicide attempts.
- Women have been found to be more often solitary drinkers but experienced 'benders' less often than men.
- The impact of female alcoholic behavior, in contrast to that of the man, is exerted at home within the family circle rather than on general society. Male alcoholics have shown aggressive and drunken driving behavior more frequently; were more often arrested for alcohol-related actions; and lost jobs and friends more often than women.

"It may be noteworthy that in our experience, even women alcoholics with undoubted loss of control commonly manage to restrict their drinking when out dining in their husband's company, or that of friends, to one or two drinks. 'I think too much of myself' or something similar, is their explanation.

"Under these circumstances, outsiders will find it more difficult to spot a woman's drinking problems early on, and courts and industry will be in a less favorable position, than with males, to initiate the therapeutie and rehabilitation process."

- The course of alcoholism is much more telescoped in the female than the male.

Said Dr Glatt: "It is remarkable how often the husband relates that for years he did not suspect this his wife was drinking, even if, in retrospect, he feels he could have done so."

Dr Glatt is honorary consultant physician, department of psychological medicine, University College Hospital, London, and medical director, Galsworthy House, Kingston-upon-Thames. He was speaking to the 24th International Institute on the Prevention and Treatment of Alcoholism.

* *Alcoholism Problems in Women and Children*

UK teens are drinking 'on a colossal scale'

By Alan Massam

LONDON — British laws relating to the consumption of alcohol by children and young people are being broken "on a colossal scale."



She's 14, but pub drinking is no problem.

That is the conclusion of the independent Consumers Association after surveying a sample of 15- to 17-year-olds.

The assoeiation asked the teenagers where, if anywhere, they had bought alcohol illegally (purchase is not permitted before age 18) and found the youngsters had "hardly ever been refused."

In fact, 35% of the sample had bought aleoholie drink in the previous week, and 61% in the previous year.

The association found beer was the drink that had been bought by most children with spirits coming next. Boys bought alcohol more often than girls.

Almost 70% of the teenagers questioned, including about half of those aged 15, said they could buy alcoholic drinks in every pub in their area. Similar "freedom" was found at clubs and discos (discotheques). About 75% of the sample said they could also buy alcohol from supermarkets and wine and spirit merchants.

"It appears therefore that supermarkets and wine and spirits merchants are the most lax in enforcing the age restrictions on selling aleohol," the association comments. "On the other hand, most children aetually buy their alcohol from pubs, bars, clubs, or diseos — presumably they prefer to drink on the spot.

"It is an offence not only for people who are under age to buy alcohol, but also for the licensee to sell it to them if he knows they are under age.

"Often, of course, it is difficult to tell how old children are. But judging from the ease with which even our 15-year-olds managed to buy alcohol, it is clear that quite a few licensees are excessively lax.

"It is also an offenee for anyone to buy an alcoholic drink for someone under 18 to drink in a bar. Nevertheless, it appears from our survey that this law, too, is often flouted.

"Clearly a blitz on enforcement is needed. At the moment, the number of prosecutions for these offences is actually falling."

The Consumers Association report goes on to take a critical look at the promotional activities of the producers of alcoholic drinks, noting they spend more than £36 million annually on press and TV advertising while health education on the perils of alcoholism is supported by the British government at a level of about £1,100,000 annually. "We think that all advertisers of alcohol should spend a proportion of their budgets on advertising which encourages sensible drinking — that is 'don't just drink, eat' and 'don't be bullied, drink at your own pace,' " the assoeiation argues.

But it is on the question of why alcohol consumption among young people is growing the report will be most telling. The association notes that in recent years, the cost of alcohol in Britain has not inereased as fast as earnings, so the average working man here ean buy more drink in exchange for an hour's work today than he could 10 years ago. (Ten years ago the average hourly rate of pay would purchase 3½ pints of beer or 1¼ double whiskies, whereas now it would buy four pints of beer or two double whiskies.)

This would seem to be one of the reasons — the faet that cost in real terms has fallen — for increased eonsumption, the report says.

"The reason why the 'real' cost of alcohol has fallen is largely that duty (tax) on alcohol doesn't go up automatically with inflation," the report adds.

"It goes up only when the Chancellor of the Exchequer makes a specific and unpopular decision in his budget.

"The Advisory Committee on Alcoholism and the House of Commons Select Committee on Expenditure both recommended recently the price of alcohol shouldn't be allowed to fall any further in real terms."

The association concludes it must support these recommendations although generally opposing unreal increases in commodity prices.

It adds that although alcohol is a source of considerable harmless pleasure to the great majority of people, something will have to be done to curb abuses. "The government, which is getting over £2,000 million a year from alcohol in duty, ought to be able to find the money to do it. First, more edueation is needed and those with a drink problem encouraged to seek help.

"Seeondly, enforcement of laws relating to alcohol needs to be made stricter. There are a number of indirect ways in which, at present, people are perhaps being eneouraged to drink more."

Decision to open drug files is minister's alone

(from page 1)

This eliminates the catch-22 that existed when the drug files were totally closed: an individual could only appeal to the Privacy Commissioner about gaining access to a file if he or she was basically positive that a file existed — something that could not be determined positively as the files were totally secret. The Privacy Commissioner could do little if anything about the situation.

The government agency in custody of the files also must notify individuals if personal information is to be transferred to another government data bank or another government agency.

An aide to the minister explained that sinee the files in question are in the health department, the decision to open them to public scrutiny is solely a deeision of the health minister. The drug user data bank was one of only two dozen, of more than 1,500 government data banks, that the cabinet decided to exempt totally from public scrutiny under the privacy provisions of the Human Rights Act.

Most of the information is submitted to the Bureau of Dangerous Drugs after a particular drug offence has been handled by a court and the police investigation is completed.

Even after the cabinet order is reversed to open the files, more changes to the drug user files are in the wind.

For example, some government offieials are now questioning the need for all of the detailed personal information contained in the files, especially if the information is to be used mainly to generate drug use statistics.

A related coneern is that the accumulation and storage of such extensive personal information in computerized files increases the dangers of misuse of the information, even with extensive internal controls — especially if all the information is not really needed.

While the health department finally moved quickly to correct this particular case, the existence of the situation in spite of the Human Rights Act has raised suspicions in some non-government circles that other violations of the spirit (if not the letter) of the Human Rights law might exist elsewhere in the government.

Special fears drive police to drink

'It's a strange type of life all the way around'

By Harvey McConnell

WASHINGTON — For two years Reverend Joseph Dooley agitated the Washington police department to set up an alcohol counselling program for the 4,100-member force.

His persistence has paid off. And it has produced something he didn't bargain for: he is running it.

From a pair of anonymous, small offices in a downtown Washington office building, Father Dooley, a Roman Catholic priest, and Reverend William Bishop, a black methodist minister, have launched The Employees Assistance Program, as it is called.

Father Dooley has spent 14 years previously as a police chaplin. He has come to understand, and to try and deal with, some of the particular stresses of a policeman's lot.

What he does know, is how much alcohol can become a problem for many officers as they try to handle the pressures of their jobs and their domestic lives.

Always has a gun

Father Dooley told **The Journal**: "We know there are a lot of officers with alcohol problems. And another thing we know is that he always has a gun on his hip, on or off duty, and that he is conscious he has it."

Visits to other police departments in the country which have already instituted alcohol counselling programs indicate what is ahead.

"It seems that more than 60% of the cases handled in the first year or two of a counselling program deal with problem drinking, or alcohol abuse in some way," he says.

There are many pressures on policemen, some of them no different than on the rest of the population. There are others that are very different.

The job is dangerous (until about five years ago Washington was one of the most violent cities in America), and the wives of policemen always know that at any minute someone could take a shot at their husbands.

Father Dooley notes the eyes of the world are always on Washington. Handling of the Hanaafi siege last year produced a tremendous filip in morale.

Stress a killer

And there is a special fear. As visiting heads of state or the President swirl around Washington, every officer knows any moment he may hear the crack of an assassin's gun.

Stress, when it is not dealt with, can be a killer, literally.

Father Dooley knows of instances "where an officer who was killed, and buried with the honors of a hero, actually lost his life because of something silly he did, or didn't do, like waiting for a backup

"He was too preoccupied."

Father Dooley has found that marriage problems among police families can have a different pallor.

The wife fears for the husband. The husband, out of force of habit, often questions his wife, or their children, as if they were suspects.

Father Dooley believes there is also a particular fear in many families "which is kind of hard to put your hand on." He thinks he knows what it is:

"There is always the fear that the wife knows that he knows how to hurt her if he really wants to. This idea: that gun.

"That's the equalizer. That's the fear always in the background.

"The man may never take the gun out, but the woman knows he is carrying that gun, and she knows he knows how to handle himself."

Among detectives, use of informants, who call home, are common. Many informants are women, and it is more than one wife who wonders if the caller is a genuine tipster.

Some 42% of the Washington force is black, and soon Bertell Jefferson will become the department's first black police chief.

'Uncle Toms'

Father Dooley: "Black policemen undergo a lot of pressure from their own community, and they are sometimes considered 'Uncle Toms'. I think they have a really tough way to go, particularly if there is any prejudice when they are out working."

The 200 women on the force have an extra stress, their sex.

"One told me the other day she has noticed always that when they are out and come upon a situation, the policewoman has to come on very strong," Father Dooley says.

"She said to me: 'I guess we do that because we have to try and get the upper hand before they get the upper hand on us.'"

Father Dooley finds the job makes many of the women officers more aggressive than they feel naturally, and this arouses an inner conflict. "Wanting to be more feminine, many turn to alcohol."

Officers on duty, if they ever go into a bar to check, are always offered free drinks. It is a custom, and many take advantage of it.

As one veteran officers succinctly puts it: "We are always told there are two things which can get a cop into trouble, and they are both free: booze and broads."

The onus for spotting officers with a drinking problem will be placed on the supervisors, whose normal job is to monitor performance.

"The key, and we are stressing this now in sessions with the supervisors, is early identification," Father Dooley adds.

"We want them to look for things like an officer being late, wearing a sloppy uniform, or having a partner who intimates he would like somebody else to ride with him."

The officers themselves are being told it is not doing the dirty on a partner if he suggests the supervisor keep an eye open for drinking.

If he thinks an officer does have a drinking problem, the supervisor will advise him to see Father Dooley or Dr Bishop. If he ignores the advice, and the problem continues, the officer can be ordered to have counselling.

Job is on the line

"We didn't have enough clout in the past when people came to see us," Father Dooley says. "Now every person in the department is going to know his or her job is on the line. If help is offered, and refused, they can be fired."

He hopes the program will be "as broad a brush as possible" and deal with family members as well. Propaganda about the program is being circulated within the department, and such groups as the police wives association.

"We hope we not only get the wives to refer a husband with a drinking problem to us, but also husbands to refer wives whom they think have the same problem."

Father Dooley planned to attend Rutgers University summer school on alcoholism. He is, in addition, looking for an officer who has had a past drinking problem, and is now comfortable with his sobriety, to head peer counselling sessions.

Father Dooley and Dr Bishop have both been placed on the department payroll. In Father Dooley's case it means he will help out part-time at a small Maryland church if needed, but his salary will come from the city.

On the advice of policemen he talked to in Boston, he won't wear his 'dog collar' most of the time. The offices will be as inconspicious as possible, quite separate from the department.

"We want them to think it is like a private visit."

There is one change in police procedure which Father Dooley wants to see come about, and he thinks it is crucial.

Washington officers, like those in many forces around the country, are required to carry their gun when off duty.

24 hours a day

"Why is it that in any other occupation, except the clergy and doctors, you are not required to be on call 24 hours a day?" he asks.

"I think the best solution would be to let the individual officer decide if he wants to take the gun home.

"Of course, some policemen are quite paranoid about the idea of being unarmed. They are afraid that one day they might run into an individual whom they have locked up.

"It could be in a restaurant or on the street, and the person he locked up may have just left prison, and have an axe to grind. That is something they live with."

Father Dooley reflects: "It's a strange type of life, all the way around."

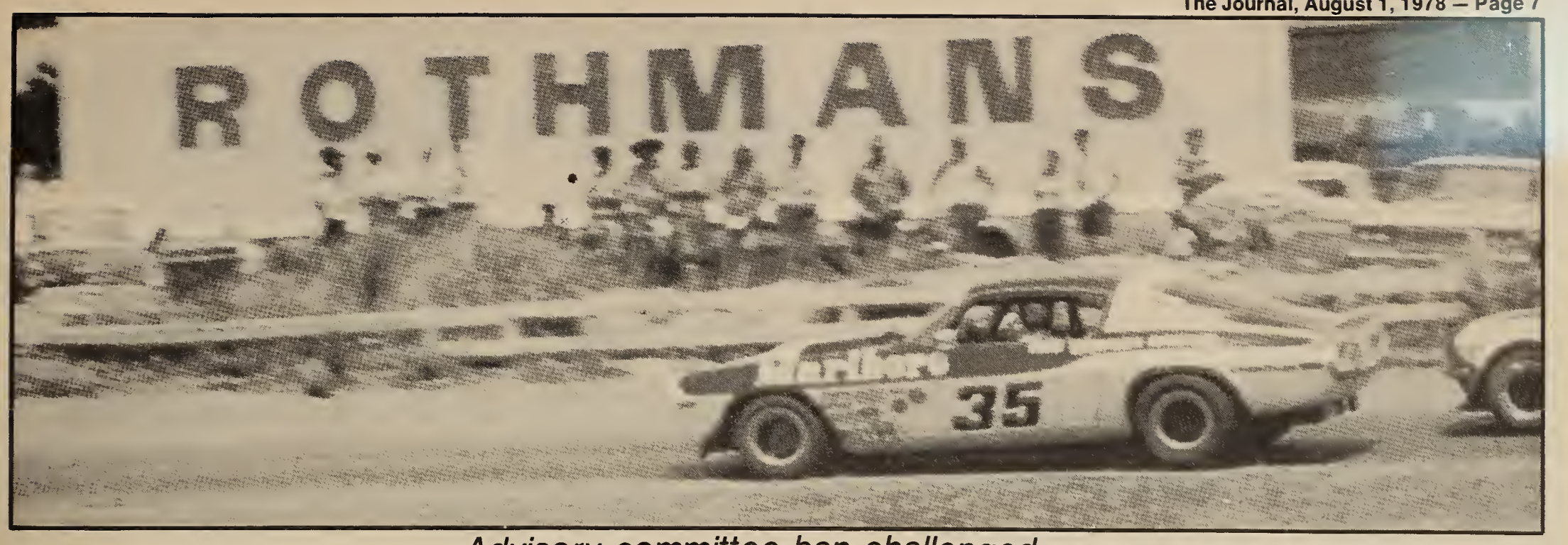


All files on Washington police and their families seeking help for alcohol problems are kept in a safe. Only Father Joseph Dooley and Reverend William Bishop, who run the assistance program, know the combination.

Photos: Harvey McConnell



A minor moment, helping a drunk in a park. The particular stresses on every officer, on and off duty, lead often to personal and family conflicts and the use of alcohol to try and resolve them.



Advisory committee ban challenged

Sporting bodies fight to keep tobacco sponsors

By Pat McCarthy

AUCKLAND, NZ — Seventeen major New Zealand sporting bodies have formed a political front to resist any restriction on sports sponsorship by tobacco, liquor, and oil interests.

Inclusion of liquor and oil is for the moment only of sideline interest. The immediate goal is to combat the government's advisory committee on smoking and health, which is recommending a ban on tobacco advertising at sponsored sports fixtures.

Such a ban, the coalition maintains, would have a "powerful, if not catastrophic" impact on many sports by stubbing out the sponsorships on which they rely.

Members of the sports group, who claim an aggregate membership of 880,000 New Zealanders, include leaders of the national bodies controlling athletics, tennis, rugby, cricket, soccer, golf, motor sports, horse racing, and trotting. Their chairman, tennis administrator Ian Wells, says they are engaged in a "war to the knife."

In what promises to be a high-powered political campaign, they intend to question candidates for November's general election on their attitude to the proposed advertising ban.

Already, the sports front has commissioned a public opinion survey which produced 78% opposition to limiting sponsorship activities.

Predictably, 96% of those questioned said their own use of tobacco, alcohol, and oil products had not been influenced by industry sponsorships of sport. Only 3% said their consumption of tobacco had been influenced by sponsorship, and 2% gave similar answers for alcohol and oil.

Under a voluntary agreement between tobacco manufacturers and the health department, television advertising and "permanent" outdoor signs away from points of sale are not allowed. The advisory committee, which wants the word "permanent" dropped — thus banning advertistising at sponsored sports events — claims the spirit of the agreement is being broken.

"Every time you turn the television on to watch the cricket you see the name of a cigarette brand," says committee chairman Geoffrey Holland, a surgeon.

Cricket has a five-year, $100,000 sponsorship deal with Rothmans NZ Ltd, the firm which has 70% of the New Zealand cigarette market.

The Rothmans Cultural and Sporting Foundation, formerly directed for 10 years by Olympic track athlete Peter Snell, has assisted about 50 sports with sponsorships and coaching schemes.

A marketing magazine editor, Ian F. Grant, has described the foundation as "undoubtedly the most successful public relations campaign this country has ever seen." He said: "Although most newspapers have an abhorrence of free advertising and public relations mentions in editorial columns, the foundation has obviously acquired, in the minds of many sub-editors, the kind of privileged position normally reserved for charitable or community service organisations."

What tobacco companies look for from sponsorships has been made clear by Gordon Gilmour, chairman of W.D. and H.O. Wills NZ Ltd: "Only a fool would expect anyone to believe that the assistance we give to cultural and sporting activities is solely charitable. Of course we look for reciprocal benefits in terms of our image and, in consequence, our business."

The government also has a stake in smoking, through reaping 31 cents in tax from every pack of cigarettes sold (most brands cost about 60 cents a pack). A higher tax, Dr Holland suggests, could be an alternative source of sports revenue if tobacco firms withdraw from sponsorships.

Addiction centre switches to 'total health'

TORONTO — One of Canada's foremost centres for the treatment of addictions is shifting its focus to "total health".

The Donwood Institute plans to develop a model health centre it hopes "will be capable of adaptation to the needs and resources of any community," says R. Gordon Bell, president of the institute.

Speaking at the First Annual Donwood Conference here, Dr Bell said expansion plans now are:

- to consider intake patterns as a whole (drugs, alcohol, food, and tobacco) as a central consideration in the design of a total health program;
- to design a model total health centre to provide guidelines for improved health from pre-natal stages to old age;
- to demonstrate that involvement in total health programs can produce rewards capable of competing effectively with those experienced by harmful intake patterns; and
- to develop an expanded training centre to include new programs to enable non-professional personnel to participate in total health programs on an avocational basis.

Dr Bell said the shift represents more of an evolution than a revolution in the Donwood program. "The basis of the Donwood approach has always been a caring community — using total health guidelines to achieve a new life free from a crippling dependence on alcohol or drugs. However, to this point, involvement in a health program has had to be secondary to a treatment plan. All candidates for our services required some kind of skilled clinical intervention before becoming involved in a personalized health program."

Mello-Mendelson win Jellinek award

ZURICH — A woman and man who form a team in both their professional and private lives are the winners for 1979 of the Jellinek Memorial Award.

Drs Nancy Mello and Jack H. Mendelson of Harvard Medical School "pioneered in bringing the study of alcoholism in humans into the laboratory," according to the committee of the Jellinek Memorial Fund which selected the winners.

The citation accompanying the award reads: "For their outstanding contribution to experimental behavioral knowledge of the determinants and consequences of excessive alcohol consumption in man; in particular for successfully applying controlled techniques of the laboratory to the experimental study of numerous scientific questions of practical relevance to a behavioral analysis of excessive alcohol consumption in man."

The two received the award here at the 24th International Institute on the Prevention and Treatment of Alcoholism organized by the International Council on Alcohol and Addictions.

The award is $1,000 each plus a bust of the late E. M. Jellinek. Members of the selection committee were Dr Howard Cappell, chairman, head of psychology and psychological studies, Addiction Research Foundation of Ontario; Dr Muriel Vogel-Sprott, department of psychology, University of Waterloo; Dr Tony Carpenter, Rutgers School of Alcohol Studies; Dr Griffith Edwards, Maudsley Hospital, London, England.

The committee said in their moving of alcoholism into the laboratory, Drs Mello and Mendelson demonstrated "the amenability of the phenomenon to scientific investigation under controlled conditions; this courageous and innovative effort has served as an example to other investigators concerned with chronic exposure to alcohol and other drugs as well.

"Their leadership in the interdisciplinary teams that were assembled over the years for this effort provided an excellent model for research in this difficult area."

CNS shifts in monkey work

NEW YORK — Rhesus monkeys addicted to heroin have been found to have structural changes in the central nervous system, which may indicate genetic mutations.

Leon Roizin of New York State Psychiatric Institute and Columbia University, says these alterations may mean heroin addicts could be damaging future generations as well as themselves.

Dr Roizin worked with six monkeys for two years, giving them daily injections of "street variety" heroin, which is made up of 20% heroin plus quinine and mannitol. Samples from the hypothalamus were then removed from each monkey's brain and studied under microscope.

Dr Roizin and colleagues found four monkeys showed definite alterations in the nuclei and nucleoli of their hypothalamus cells, which contain genetic material and help to synthesize protein.

Dr Roizin is studying these samples to see whether the structural changes are associated with chromosomal (genetic) damage. If they are, Dr Roizin hopes to find if this damage can be reversed.

If heroin is mutagenic, he says narcotic antagonists like methadone, naltrexone, and LAAM, which are structurally similar, may also cause genetic damage. Dr Roizin presented his group's findings at the Federation of American Societies for Experimental Biology.

Nix to asbestos-smoke mix

MONTREAL — The asbestos company Johns-Manville has announced smoking will no longer be permitted at their Asbestos, Quebec plant.

The reason? Health studies have shown the incidence of lung cancer in asbestos workers who smoke is 90 to 92 times greater than in those who do not smoke.

Smoking will not be permitted anywhere on company property and some 2,500 workers at the plant who smoke (about one-half the worker complement) will either have to kick the habit or smoke off the job.

The "No Smoking" rule at Asbestos is part of a company-wide crackdown and is already in effect at some United States plants. At Asbestos, the company and the union have yet to negotiate what the penalties might be for smokers who rufuse to butt out. Meanwhile, 250 workers at the Johns-Manville plant in Brossard, Que have not yet been advised how the new ruling will affect them.

Drug use aid: 48% are from minorities

WASHINGTON — Some 48% of all drug abusers tested in programs financed by the federal government are members of minority groups. The overwhelming majority are addicted to heroin.

Karst Besterman, acting director of the National Institute on Drug Abuse, (NIDA) said studies show 78% of the blacks and Hispanics who seek help are heroin addicts. Among white drug abusers, the figure drops to 38%.

Mr Besterman told the House of Representatives select committee on narcotics that problems with marijuana are the second most frequent reason abusers seek help. However, among Indians and Hispanics, sniffing of glue and other petrochemicals ranks second on the problem list.

EDITOR
Anne MacLennan

STAFF WRITER/PRODUCTION EDITOR
Karin Pargas

CONTRIBUTING EDITORS
Harvey McConnell (Washington)
John Shaughnessy (Toronto)

SCIENCE EDITOR
Dr Ruth Segal

The Journal

Published by Addiction Research Foundation of Ontario
33 Russell St, Toronto, (416) 595-6053

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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Comment

Bourne departure leaves a void

By John Shaughnessy

Peter Bourne's resignation from his post as special advisor on health matters to United States President Jimmy Carter is shocking news. In our view he should stand and fight. By resigning when he did he let the American people down.

Dr Bourne has admitted prescribing 15 tablets of methaqualone, a controlled drug, for a patient who was employed in his government office. To protect the patient's confidentiality, he used a pseudonym on the prescription. When news of his action became public, Dr Bourne announced he would take a leave of absence so he could clear his name of any potential charges that he had acted unethically or illegally. Within hours he resigned.

In a statement announcing his leave of absence, Dr Bourne said he had consulted legal counsel and believed he had done nothing legally or morally wrong. That being the case, he should have stayed in office until the matter was resolved.

As a psychiatrist, Dr Bourne has a duty to protect his patient's confidentiality. In this case, he felt he could provide such protection only by using a pseudonym for the patient on the prescription. Dr Bourne may have been wrong in using the pseudonym, but the controversy again raises the issue of how far a patient's confidentiality ought to be protected.

- Does every patient have a right to everything involved in his or her medical treatment being kept secret?
- Do the same principles apply if the patient has a communicable disease?
- Do they apply if the medical examination, psychiatric or otherwise, reveals the patient is a danger to the public?
- Do they apply if the patient is a prominent and influential figure — say a president or a prime minister — and medical examination reveals such a patient is incapable of doing his or her job, and the public is at risk because of it?

This debate has never been clearly resolved. Doctors argue their first duty is to the patient, that without confidentiality guaranteed they cannot serve their patients. Others argue that doctors are also members of the community and, in some instances, the public good outweighs an individual's right to confidentiality.

Dr Bourne obviously decided his duty as a psychiatrist in this case was to protect his patient's confidentiality, that no public good would be served by risking disclosure of the patient's name or treatment.

As a psychiatrist, Dr Bourne may well be right. But he is not only a psychiatrist, he is special advisor on health matters to the president of the United States.

If most physicians were to face the questions Dr Bourne had to face, their answers would not carry the same significance. Certainly, they would not have to take a leave of absence or resign if someone disagreed.

Dr Bourne says both he and his patient were concerned about the protection of her confidentiality both with regard to her taking the medication and to the creation of a record anywhere that she had been treated by a psychiatrist. What is saddening about the whole affair is that both felt this would be damaging.

The attitude may be realisitc but the implication is that we have not advanced very far in our acceptance of mental illness. Dr Bourne, as advisor on health matters to the president of the United States, should surely be in the foreground of those promoting the idea that mental illness is just that — an illness. A person receiving psychiatric care is no more "crazy" than a person receiving care for a broken leg is "lame."

By choosing to protect his patient's confidentiality in the manner he did, Dr Bourne is saying he doesn't believe this is so, or at least he doesn't believe the American public believes it's so, especially where a government employee is the patient.

Dr Bourne, unfortunately, may be right. But if he is, it should be one of his jobs to try to change such attitudes. Instead he has given obeisance to the status quo.

Perhaps where Dr Bourne went wrong was in practising medicine at all while serving as special advisor to the president.

In our view, Dr Bourne has acted imprudently. Apparently an investigation is underway as to whether he is guilty of illegally prescribing drugs. Until that issue is decided, we can see no reason for his resignation.

The drug abuse field in the United States has suffered a serious blow with the loss of Dr Bourne. Through him, those in the drug abuse field had the ear of the president in a way unparalleled in any other administration. With Dr Bourne gone, and the Office of Drug Abuse Policy closed, officials in the field will have a much more difficult time making their voices heard in Washington. Even if a replacement is appointed, it is unlikely he or she will have the same influence on the president as Dr Bourne did.

We are sorry to see him go, especially in the circumstances that now surround him.



'Big deal! How do they think I've endured my ol' man all these years?'

Letters to the Editor

No 'exciting possibility' in pot

I read with interest J. Thomas Ungerleider's criticisms of the cannabis factsheet, and the reply by Drs Harold and Oriana Kalant. (**The Journal**, May).

Dr Ungerleider speaks of the "exciting possible therapeutic uses of cannabis" in alcoholism. I suppose that anything could be an "exciting possibility" in alcoholism therapy — even alcohol itself, if we are to believe the recent claims of "controlled drinking" advocates.

However, fanciful possibilities aside, here in the everyday realities of alcoholism treatment, we have not found it at all beneficial to encourage substitution of one chemical for another. In my own clinical experience with very large numbers of alcoholics in upper middle-class communities (Southern California), an urban ghetto (Harlem) and rural communities (Upstate New York), I have been impressed with the very substantial correlation between substitute drug use and an eventual return to destructive drinking in recovering alcoholics. And cannabis has not proven itself to be an exception to this general rule of alcoholism treatment.

It is possible, of course, that my particular samples are biased. As do most clinicians, I tend to see those patients who fail. There may be some number of alcoholics in continuing recovery who are enjoying a happy, productive, and contented sobriety through cannabis use. However, until competent research has shown this to be the case, I regard it is as inappropriate to characterize this substance as having "exciting possible therapeutic uses" in alcoholism. The history of drug therapy for alcoholism cautions against such naive optimism.

John Wallace, Phd,
Director, Alcoholism Services
County of Putnam
Community Mental Health Board
Mahopac, New York

An Amazon lesson

The article on the use of alcohol along the Amazon (**The Journal**, March) struck me as lacking in point of view.

Flipping back and forth from factual reporting to viewing with alarm, allowed the reader to miss the point that these people seem to have integrated alcohol use into their society more rationally than we have.

No new experience to the Yaguas or Mestizos, the drunken spree seems to serve as an opportunity for orgiastic celebration yet remain controlled by positive pressure so as to avoid what their society might describe as "drink related crime" . . . . violence and infidelity.

Perhaps the sentence which says the Yaguas "live in extended families, have no class system and have adopted only a modicum of 'civilized' items," could serve as a guide in our own efforts to avoid the destructive use of chemicals.

John J. McVernon
Director, Community Projects
PACT/NADAP
New York, NY

A researcher remembers:

'Lung cancer from cigarette smoking...? ...I saw my first case in 1919'

NEW ORLEANS — The scene is the autopsy room at Washington University medical school in St Louis. A group of medical students is watching the autopsy that will reveal the existence of an amazing new disease — lung cancer.

The date? 1919.

One of the onlookers that day was Alton Ochsner, who was to become the founder of the Ochsner Clinic in New Orleans, one of the largest clinics in the United States, and the first individual definitely to link cigarette smoking with lung cancer.

Since that time, Dr Ochsner, 82, has spent much time on the road, continuing to point out this link to new generations in the estimated 150 talks he now gives on the subject each year. Jean McCann talked to him recently at the American College Health Association here.

I'm now professor emeritus at Tulane University, having served as chairman of the department of surgery for 32 years. I still see patients every day, I travel a good deal, and I'm very active in civic work.

It's not hard for me to reminisce. My interest in the connection between smoking and lung cancer began serendipitously. When I was a medical student in 1919 at Washington University, there was a case of cancer of the lung admitted to Barnes Hospital, which is our teaching hospital and, as usual, the patient died.

Our professor of medicine, who was a great pathologist as well as a great internist, Dr George Dock, wanted the senior classes to witness the autopsy because, as he said, the condition was so rare that he thought we'd never see another case as long as we lived. At the time I was very young and very impressionable, and I was extremely impressed by the rarity of this condition.

I didn't see another case until 1936. I came to Tulane as a professor of surgery in 1927 and, in 1936, I saw nine cases within six months of this disease, which for 17 years previously I wasn't supposed to see the rest of my life.

Epidemic

Well, there had to be a cause of this sudden epidemic. These patients were all men, they all smoked cigarettes heavily, and they all began smoking in the first World War, 20 years previously. I did some research and found out there were very few cigarettes consumed before the first World War, so I had the temerity at that time to say I thought the cause of this new epidemic was cigarette smoking, and published it at that time.

The evidence was pretty nebulous, and nobody believed me, then. But now we certainly have the proof of it.

Today, I'll be talking about the health hazards of tobacco. While my first interest in it began with cancer of the lung, I will talk about emphysema and other hazards too. Of course, cancer of the lung is a very important part of it, because this year, 100,000 people will die of this condition which, in 1919, I wasn't supposed to see for the rest of my life. And all but about 5% of these will have been caused by smoking. This is the most rapidly increasing cancer we have. It kills more men than any other cancer, and it's one cancer that is preventable.

Of course, for every case of cancer of the lung that it causes, there are at least 50 cases of cardiovascular disease that are caused by smoking.

So, it is without a doubt our major public health hazard. In 1975, 360,000 people died because of tobacco use, according to the Surgeon General — US Public Health Service. These are cardiac and other vascular deaths, emphysema, cancer of the lung, cancer of the mouth, tongue, larynx, esophagus, bladder, and pancreas. These are all linked with tobacco use.

More are quitting

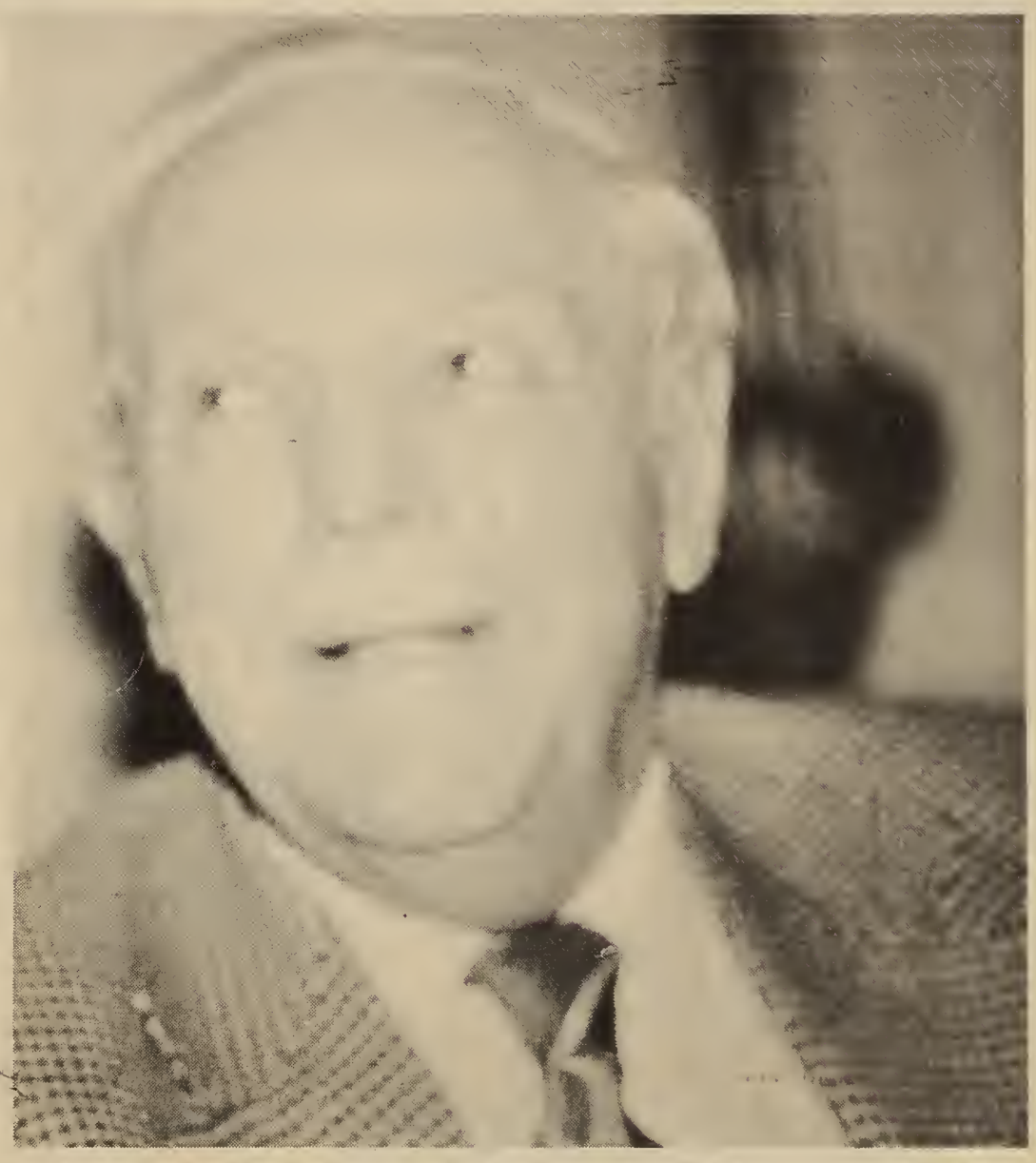
Less than 27% of physicians are smoking now. They're stopping. Ten years ago, 75% smoked. The physicians have stopped; the men have stopped. There are about 36 million ex-cigarette smokers in the United States today. The tobacco people talk about the increased sale of cigarettes, and that's true, but it's not all in the US. They're talking about the export as well.

A good deal of this is export, although there is an increase of cigarette smoking among the teenagers, and particularly the young girls, more so than the boys.

It's very simple to quit if they're motivated. I've told a lot of people they have to stop smoking, or should stop. They said they couldn't. When they got their cancer, or had their heart attack, they stopped immediately. I said to them: I thought you told me you couldn't. Well, they said: "I did, as soon as I knew I had to."

In other words, it's a question of motivation. It is not difficult if one really wants to stop smoking.

Now there are two things about tobacco: one is addiction, and this lasts a very short period of time, about three to five days; after that, it's an habituation. Anything that one does as often as they smoke a cigarette, it's hard to break that habit. They associate it with something . . . with a cup of coffee, with a drink, or after a meal, or sitting down with the television, or answering the telephone, talking to somebody. The association is an important thing.



Alton Oschner was the first individual definitely to link cigarette smoking and cancer.

Now I tell people to get a clear cigarette holder, and every time they want a cigarette, to just suck on that. It's actually nothing but a pacifier. It's a preservation of the suckling reflex.

Doctors can quit. There are only two types of doctors who don't quit. One is the individual who is in the employ of the tobacco company, indirectly, as well as directly. And the others are those who are addicted, and they can quit if they want to. I think it's obligatory for the medical profession to do it because our obligation is not only the treatment of disease but prevention. And the principal preventive mechanism available today is the absence of the use of tobacco.

'Cold turkey'

The problem of addiction is not very great, and it only lasts three to five days. It varies a good deal. Some people get very jittery. Others do not, but it lasts only a very short period of time. If the jitters are very bad, I think it's all right to take a sedative, but most people do not need this. I think they should quit cold turkey.

The important thing to emphasize to people who have quit is that they should not take the first cigarette. They're like the alcoholic. Very often people will stop smoking, and they're proud of it, and their friends are proud of it, and they'll go to a cocktail party and their friends will say 'Well, Bill, I'm glad you stopped. I think you're to be admired for it. Why don't you just try one?' If he tries one, that's bad. He's just like an alcoholic who takes that first drink.

I think everybody today realizes the hazards . . . there are very few people now unaware of this. The reason people don't stop is the human frailty of thinking it can't happen to us. We drive too fast. We know it's dangerous. We do things we do because we think we're immune. We know it's bad. We think it can't happen to us, but it can happen to us, and it will happen to us, if we continue.

I get to the clinic (Ochsner Clinic) every morning about 8 o'clock and I get home about five. I do a good deal of writing. I'm very active in civic work, I do a lot of that. And I travel a lot in talking. For instance, this afternoon I'm driving over to the Gulf Coast, so I can talk over there in the morning. I'll be back tomorrow afternoon and Saturday I fly to Houston to participate in a ground-breaking ceremony at Baylor University.

I'm supposed to be retired, but I think retirement would be the worst thing that could happen. I think obligatory retirement is perfectly horrible.



(Dr Ochsner founded the clinic bearing his name right after World War II, with a staff of about 20 doctors. Now, there are 168 staff doctors and about 170 resident doctors-in-training. The clinic, with some 4,000 employees, has the second largest payroll in the state of Louisiana.)

Women smokers prone to chronic bronchitis

PARIS — Although women are less likely to suffer from chronic bronchitis than men, they appear to be more sensitive to the bronchopathogenic effects of heavy smoking, a study here was suggested.

Renata Liard, of the Institut National de la Santé et de la Récherche Médicale (INSERM), said a study of 900 adults showed 8.1% of female non-smokers could be considered to have chronic bronchitis as opposed to 16.4% of male non-smokers.

When smokers were considered, however, the percentage of chronic bronchitis among the women rose more rapidly than among the men; and for women smoking more than 20 cigarettes a day, 42.9% had chronic bronchitis compared to 31% of the men smoking at least 20 cigarettes a day.

Another way of looking at the figures, said Ms Liard, is that while a smoker has 2.3 times the risk of a non-smoker of developing chronic bronchitis, this risk is different according to sex: male smokers have a risk 1.6 times that of non-smoking men, whereas women smokers' risk is 3.3 times that of their non-smoking sisters.

Ms Liard said an analysis of the results showed smoking to be the primary risk factor for the development of chronic bronchitis in women.

She explained that the 900 subjects of the study were seen in a centre for occupational medicine (although they came from a variety of different professions and industries). The definition used for chronic bronchitis was that of the British Medical Research Council, and results were taken mostly from questionnaires filled out by the subjects. Tests of vital capacity were also carried out, and FEV^1 was found to be diminished in female, but not male, smokers.

In another INSERM study, conducted by Jacqueline Cooreman, Professor Guy Burgard, and Dr Metz-Marcy, the adolescent found most likely to have some sort of respiratory pathology was female, smoked at least 10 cigarettes a day, and had suffered a broncho-pulmonary disease within the past 12 months.

A total of 64.9% of this group had some sort of respiratory symptomatology, said Ms Cooreman. The definition of respiratory disease in this group was "anyone who gave at least one 'yes' to our list of symptoms."

By contrast, the profile of the adolescent least likely to suffer from such pathology was a male non-smoker, who had not suffered any broncho-pulmonary disease in the year preceding the study, who was under 16, going to a co-ed school and not boarding in. Only 13.3% of subjects in this group had any sort of respiratory symptoms.

Ms Cooreman said the greatest risk factor was smoking, followed by respiratory antecedents. The fact girls were more likely than boys to have some sort of symptoms was a reversal of what is found in the adult, where non-smoking women have less respiratory pathology than non-smoking men, she said.

The study, which analyzed questionnaires by 27,981 schoolchildren, also attempted to discover what external influences led to smoking. The children of smokers, and particularly of smoking mothers, were more likely to smoke than the children of non-smokers. In lycees where professors were allowed to smoke, a greater proportion of adolescents smoked than in those where smoking was not allowed.

A real ale shoulder?

LONDON — The Barmaid's Arms has always been popular, but the barmaid's shoulder is another story.

A blonde woman recently visited the office of Dr Steve Cembrowitz complaining of upper chest pain. She told the doctor she was a barmaid in a pub that was serving beer in the old style — where the pints are dispensed by a hand pump instead of gas-powered taps.

Dr Cembrowitz, writing in *World Medicine*, said: "The consequent increase in muscular activity of the shoulder .... resulted in chronic strain of the shoulder fibres."

"Ale shoulder" appears to have joined housemaids' knees, tennis elbow, skiers' boot top fractures and a host of other ailments on the list of occupational hazards.

Subtle clues to abusers

Teachers get drug guide

By Thomas Land

LONDON — A pamphlet issued by Britain's department of education and science advises teachers not to rely on isolated signs of drug abuse, such as injection marks or the smell of burning cannabis.

They are advised, instead, to look for signs of uncharacteristic changes of behavior which, for whatever reason they occur, call for special attention and perhaps treatment.

Teaching and discussion about drugs has a place in education at all stages of school life but not, says the pamphlet, in the form of a terrifying film show, or a lecture from a visiting expert in reaction to some real or imagined crisis; it should be part of health education.

The pamphlet, *Health Education in Schools*, * contains basic information and advice intended for use by teachers, parents, and others in their discussions with young people.

It says the extent of drug misuse, especially among young people, is impossible to judge because the practice, being illegal, is not widely admitted. But figures for the number of registered narcotic addicts show that numbers in the age range of 14 to 19 years fell from 637 to 279 in 1972.

The study explains many attempts have been made by doctors, teachers, and sociologists in several countries to understand why some youngsters misuse drugs. Basic reasons which have emerged are they enjoy, at least for a short time, the physical and mental sensations induced by the drugs; curiosity; or association with the behavior of what appears to be a particularly attractive group of contemporaries.

When pupils are found to be experimenting with drugs, the pamphlet emphasizes, the responsibility to decide the wisest course of action should rest with the heads of schools. Parents, it is believed, might be distressed and confused and, indeed, there may also be an acute conflict between parent and child. When heads are certain that drugs are being misused by members of their schools, they have the duty to inform the police.

The ministry's pamphlet also points out little research has been done on the attitudes of youngsters to drink, although a recent study of a sample group aged 14 to 17 years, suggests "toughness" and "sociability" figure prominently in their perception of drink. Similar reasons also emerge in investigations into the motivation of children towards smoking.

A successful method of introducing the topic of alcohol into school studies is to find ways in which the subject fits naturally into various parts of the curriculum. It would, for example, be difficult to plan a course of English literature or the history of the 18th and 19th centuries without reference to the temperance movements, the manners and morals of the day, or the wine growing areas of Europe.

Physical education allows discussion of the effect of alcohol and drugs, and any discussion on accidents must lead to the topic of drinking and driving.

Home economics provides opportunities for considering the different types of drinks, and their compatibility with food, the study of advertising and the techniques of mass persuasion, consideration of the reasons which cause people to drink, and the dangers of excessive drinking.

Turning to smoking, the pamphlet says from the various studies and surveys undertaken over the years, it appears factors which encourage smoking among the young include the availability of cigarettes, a lack of social confidence, curiosity, parental example, and the smoking habits of friends and siblings. Parental and school attitudes, the risk to health, and the unpleasant side effects of nicotine, are the main factors which discourage smoking.

Teachers are advised classroom discussion on all forms of drug misuse (including smoking and drinking) can prove useful when pupils are asked to take into account the expectations of others such as doctors and cigarette manufacturers who are often in conflict, and to understand why this is so. They will gradually realize their personal feelings about smoking may be derived from influences of which they are not fully aware until they are pointed out to them.

* *Health Education in Schools*, **The Department of Education and Science, Elizabeth House, York Road, London, SE 7PH, or HMSO, England, at £2.50 net.**

'Antabuse is no sanction'

AUCKLAND, NZ — Antabuse implantation should be offered a patient only to strengthen already-present acceptance of alcoholism, according to Robert J. M. Crawford, medical officer of New Zealand's only hospital with an inpatient program for alcoholics.

Dr Crawford, of Queen Mary Hospital, Hanmer Springs, said in a letter to the *New Zealand Medical Journal*: "It must on no account be used as a sanction against drinking — something which is both dangerous and ineffective."

Giving his experience with 20 cases of Antabuse implantation as an adjunct to alcoholism therapy, he reported 13 successes. He described four as failures and said the outcome was unknown in three cases.

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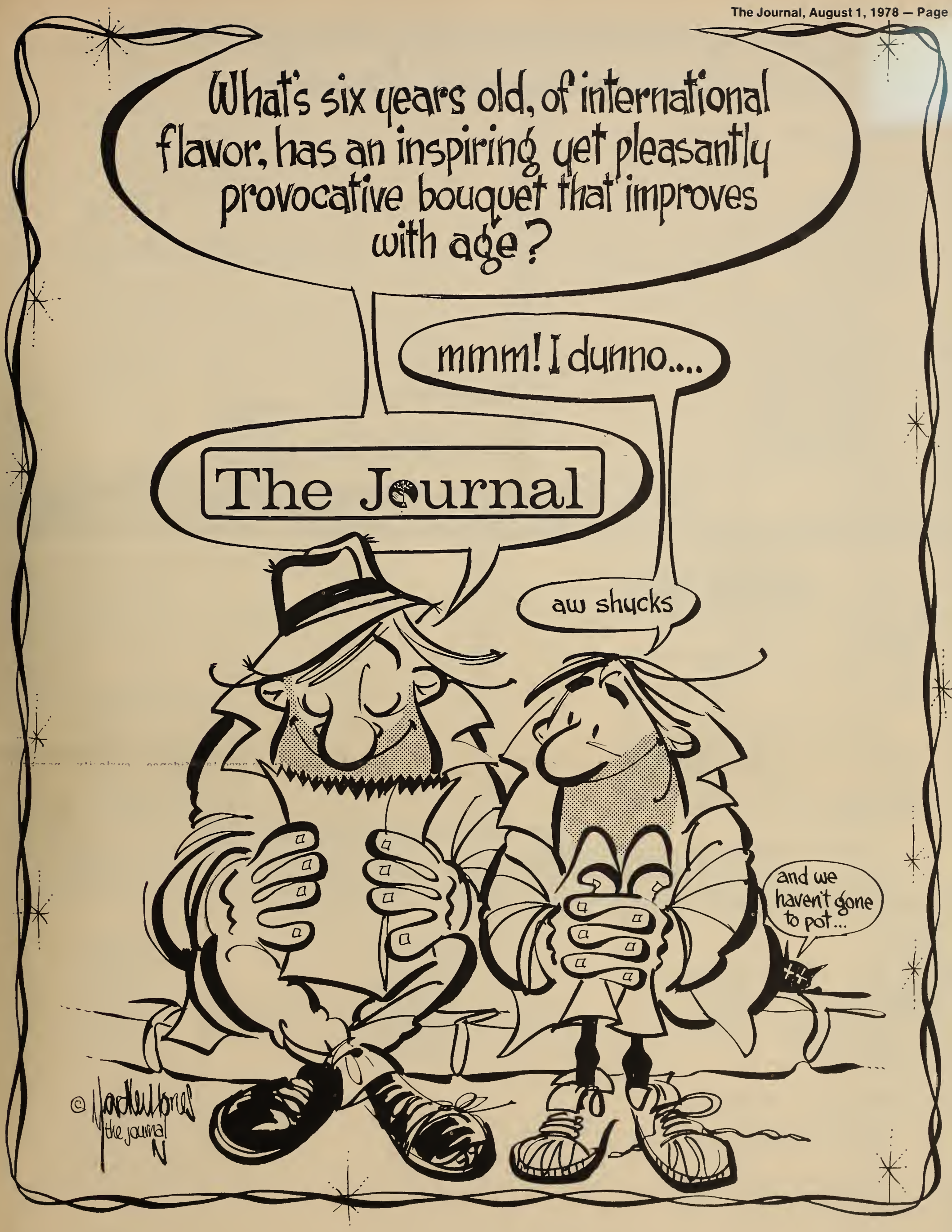
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Kiwis scorned for copying treatment units

By Tony Garnier

WELLINGTON, NZ — A New Zealand doctor has strongly criticized this country's policy of following overseas models of setting up hospital units for the treatment of alcoholics.

In line with the New Zealand government's policy of expanding community health programs, many hospital boards are in the process of establishing an alcohol and drug addiction service.

But L M Franklin — a retired psychiatrist — believes that by setting up hospital units, New Zealand is in danger of adopting a concept of alcoholism, that it is a "disease", which has fulfilled its role and could become "a dogma and an obstacle to further advance."

While alcohol abuse is of medical concern, it is not itself susceptible to medical treatment, he believes. "Alcoholism is not a unitary condition and the only feature common to all alcoholics is that they drink a lot."

The disease theory developed in Europe last century had led naturally to medical treatment for alcoholism. However, essentially all the many treatment regimes "amount to education and support, for which medical expertise is not necessary.

"And no treatment has been shown to have specific value and it is impossible to evaluate one against another," says Dr Franklin.

"The outcome depends more on the characteristics of the patient than on the treatment he is given — a stable social background and an absence of psychopathic traits make for a favorable prognosis. Inpatients do no better than outpatients; neither the patient's "motivation" on starting treatment, nor the length of treatment, affect the outcome," he believes.

A London survey by random sampling of a population of 100,000 (Cartwright, Shaw, Sprately, 1975) indicated that many people with drinking problems overcome them "quite easily" and resume social drinking. A few seem to have personality problems which make such an outcome unlikely and this group was commonly but mistakenly believed to be the only type of alcoholic. Such people tend to deny rather than face personal problems and their denial of their drinking problem makes them difficult to help.

Alcoholics Anonymous may break through the denial with something like a religious conversion. And AA had dedicated missionaries who preached self-help. "But they usually accept the disease theory implicitly, perhaps as a sophisticated form of denial," says Dr Franklin.

"If its validity is questioned, some — especially alcoholic doctors — may take offence. This has somewhat inhibited free discussion."

There is no cut-off point when socially accepted drinking habits became alcoholism "for it is only the exposed tip of a problem that permeates our culture," he says.

In Dr Franklin's view, a change in public attitude is essential and would do more than "any number of hospital units."

The planned extended treatment facilities would not reduce the incidence of alcoholism.

The real need, he says, is to "devise appropriate responses in the community to alcohol-related problems.

"Alcoholism the disease becomes increasingly insubstantial as one tries to grasp it — a more practical model for today is of alcohol-related problems which have medical, psychological, or social aspects.

"The need is not so much to treat alcoholics as to devise appropriate responses in the community to alcohol-related problems. This can best be met by multi-diciplinary teams."

Dr Franklin concludes that if New Zealand's Alcoholic Liquor Advisory Council were to initiate a change in public attitude it may have done more to stem the flood of alcohol-related problems than any number of hospital units for the treatment of alcoholics.

However, while Dr Franklin's point of view has been widely publicized and accepted by medical authorities, there has been no sign from hospital boards that it will be other than "noted." The planned hospital unit program appears to be too far advanced to be significantly changed.

DWI defence is challenged

AUCKLAND, NZ — A New Zealand authority on pre-hospital emergency care has challenged the moral attitude of some lawyers who defend drunken drivers in court.

Morgan Fahey, of Christchurch, said he recognized they had "an ethical duty to defend their client, no matter how many lies he has told in defence," but questioned "their moral attitude in failing to help the basic problem of alcoholism."

Dr Fahey said repeated offenders should be identified to the courts as alcoholics who needed investigation and treatment.

Around the World

Frail GP

A 77-year-old British GP has testified to the General Medical Council's discipline committee that he was forced to prescribe dangerous drugs after addicts beat him up in his surgery. Dr Frederick Morton-Gore told the committee: "I know I should not have written the prescriptions, but was I supposed to get punched on the jaw? I do the best I can, but I am not going to sit there and be thumped." Dr Morton-Gore was found guilty, nevertheless, of serious professional misconduct. Chairman Sir Robert Wright, said the committee had noted he had retired from practice, but added: "We consider that you should remain under our surveillance."

Ban Smoking

The New Zealand Medical Association has decided to ask the government to ban smoking in all enclosed public places, including public buildings and transport. It also urged doctors not to smoke in their professional offices, and to ban smoking in waiting rooms.

Severe Problem

Alcoholism is "unmistakably a severe mental health problem in Mexico," according to Carlos Campillo-Serrano, coordinator of the area of social science research, Centro Mexicano de Estudios en Farmacodependencia. The death rate from hepatic cirrhosis, constant for the last 10 years, is an average of 20 per 100,000 people. Death rates from alcoholism and alcoholic psychoses have been estimated at 4.5% per 100,000 population between 1963 and 1969. Although suicide rates in Mexico are relatively low, an estimated 4% in 1967 were related to alcohol consumption, said Dr Campillo-Serrano.

Cut and Run

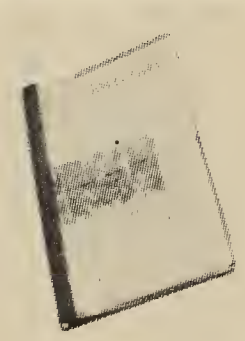
A Japanese surgeon opened a drug smuggler's stomach to recover the contraband he had swallowed in tiny rubber bags, only to have the man's wife and an accomplice grab them and run away, police said in Fukuoka recently.

Swedish campaign

The Swedish government is engaged in a vigorous campaign against smoking. In the past year, cigarette consumption has declined for the first time since the end of World War II, and expectations are it will drop even further as a result of various measures. At the beginning of 1977, for example, a new labelling law went into effect that requires manufacturers to print a repertory of 16 different warnings on cigarette packages. The warnings are rotated annually and specifically caution that "smoking during pregnancy may harm the child," or that "non-smokers have longer average lives than smokers."

Greenland rations

Greenlanders have rejected a total ban on alcohol but agree to a "rationing" system to help them sober up before they start ruling themselves. A referendum held recently showed that 48% of the voters — largely nomadic Eskimo hunters and fishermen — favored rationing, and 38% wanted a total ban. The referendum was sparked by the Greenlanders' heavy drinking problem — an average of six gallons of pure alcohol annually per man, woman, and child — and Danish plans to grant the island autonomy next year. Prohibition advocates say nine of 10 crimes in Greenland are committed under the influence of alcohol.



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BOOK

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Authors: Frederick B. Glaser, M.D. **$14.95**
Stephanie W. Greenberg, M.A.
Morris Barrett, M.P.H.

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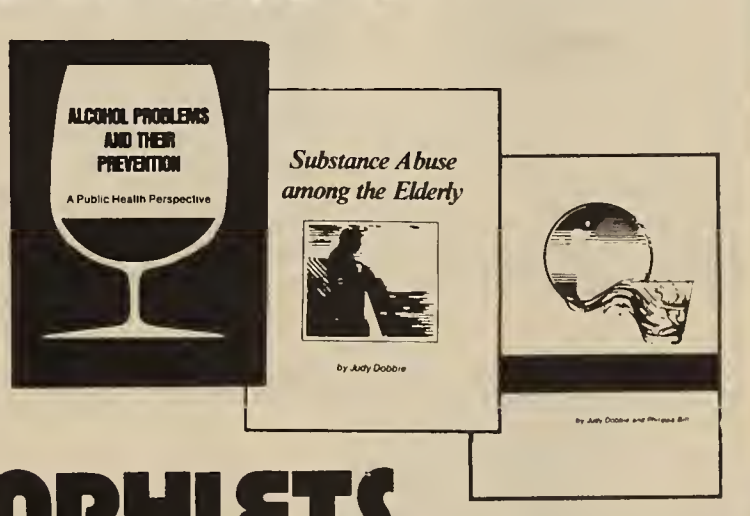
Target Audience: Teachers, social workers, health professionals, and general audiences of mid-teens and older. Especially useful in learning or teaching situations.

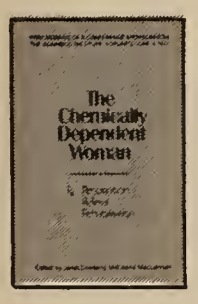
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PROCEEDINGS

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New Books

by RON HALL

The Impact Of Alcoholism

. . . by Steven F. Bucky

This book examines the question of the impact of alcoholism by considering symptoms, medical aspects, personal and emotional aspects, legal aspects, interpersonal aspects, interpersonal effects, effects on work performance, treatment, and attitude and behavior changes. A description of the symptoms from the pre-alcoholic stage to the chronic stage is followed by descriptions of the physical effects of alcohol on the body, intoxicated states, withdrawal syndromes, and Antabuse as a treatment agent. Common personality characteristics of alcoholics are presented as are other emotional and behavioral issues. The effects of alcohol on members of the family grouping are discussed, and a comparison is made between male and female alcoholics. The alcoholic worker is described, and points of observation are provided for the supervisor. A chapter on treatment presents information on Alcoholics Anonymous, biofeedback, psychodrama, and power motivation training.

(Hazelden Books, Box 176, Center City, Minnesota, 55012. 1978. 126 p. $3.95.)

Young Alcoholics

. . . by Tom Alibrandi

Through this book, the author hopes to provide some answers to the problems associated with alcoholism and young people, to clear up existing myths about alcoholism, to state clearly the problem of teen and pre-teen alcohol abuse, to suggest methods for detection and interception of alcohol problems among youth, and to assess creatively some of the obstacles that stand in the way of adult awareness of the problem. A discussion of the reasons for the growing popularity of alcohol among youth is followed by a description of theories and myths. Identification of the alcoholic, the young female alcoholic, the meaning of education and prevention, and advice for parents are other topics presented. The youth program at the Alcoholism Council of Orange County, California, is described. The second part of the book is devoted to a description of a survey of drinking patterns and problem drinking among youth in Orange County. Based on the survey findings, a peer modelling approach to prevention with preteens and intervention with youth alcohol offenders was sketched, and recommendations for its implementation were made.

(CompCare Publications, 2415 Annapolis Lane, Suite 140, Minneapolis, Minnesota, 55441. 1978. 237p. $5.50.)

Other Books

The Human Nervous System: An Anatomical Viewpoint. 2nd Edition — Barr, M. L. Harper and Row, Hagerstown, 1974, Neurohistology, spinal cord, brain stem, etc. Review of major systems, visual, vestibular, etc. Blood supply and meniges. Glossary, illustrations. Appendix. Index. 408p.

The British Experience With Narcotic Dependency — Russell, J. A., and McNicoll, A. Province of British Columbia, Ministry of Health, 1978. Alcohol and Drug Commission, historical review, legal heroin as an incentive to treatment, jurisdictional problems, enforcement strategies. Appendix. References. 14p.

Hallucinogenic Agents — Brimblecombe, R. W., and Pinder, R. M. Wright-Scientechnica, Bristol, 1975. Evaluation of hallucinogenic activity, phenylalkylamine, indolealkylamine, cannabis, drugs affecting cholonergic systems, phencyclidine, mechanisms of action of hallucinogenic agents. Bibliography. Index. 272p. $30.

Psychiatric Aspects Of Opiate Dependence — Kurland, A. A. C.R.C. Press, Inc, West Palm Beach, 1978. Personality, psychodiagnostics, prognosis, psychodynamics, deaddictive mechanisms, clinical issues and case histories, the future of narcotic addiction. Bibliography. Index. 273p.

Etobicoke Survey Of Women's Use of Psychotropic Medication: Abridged — Archer, C. M. L., Benner, M. A., and Zaks-Walker, L. Committee Concerned With Women's Health Issues In Etobicoke, Toronto, 1978. 18p.

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six point scale. For further information, contact Linda Chung, coordinator of the group at (416) 595-6150.

Changing Images Of Women Drinkers

Subject Heading: Women and alcohol.
Details: 24 minutes, ¾" U-Matic videotape, color, sound.
Synopsis: Different aspects of alcohol in relation to women are given. Historical attitudes toward women who drink are explored. The difference in treatment received by women in contrast to men is criticized. Two case studies of women problem drinkers illustrate symptoms and the treatment that can help the woman be rehabilitated.
General Evaluation: Fair to good (3.4). This tape was contemporary and informative but with an unclear message. The A/V Group liked what the tape said about drugs, and felt it could aid in decision making around the abuse of drugs.
Recommended Use: Of benefit to adult audiences, especially health professionals.

Hidden Alcoholics: Why Is Mommy Sick?

Subject Heading: Women and alcohol, alcohol and the family.
Synopsis: Jan Clayton, an actress, and Margaret Flemming, an ex-teacher are alcoholics. They have felt public disapproval and found help difficult to obtain. They tell their stories in order to raise awareness of the enormity of the female alcoholic problem, and urge that facilities be developed to deal with their unique situation. Danger signals of alcoholism are listed, and the film emphasizes the lack of society's involvement with women alcoholics.
General Evaluation: Poor to fair (2.5). A boring film of poor technical quality, this film received moderate ratings in all other categories.
Recommended Use: With the presence of a resource person, this film may benefit audiences of 15 years of age and older.

Don't Let It Bother You

Subject Heading: Alcohol and the family, women and alcohol.
Details: 26 minutes, 16 mm, color, sound.
Synopsis: A separated man makes a film to show the drinking habits of his ex-wife and her friends, and the effects they have on their teenage son. The wife gives two parties where much drinking and socializing occurs. After the first party, the wife is forced into a sexual encounter with one of the guests. At the second party, many of the activities are repeated. After excessive drinking, one of the guests is involved in a car accident. The teenage son, after witnessing all this, runs away from home.
General Evaluation: Poor (1.8). An uninformative and boring film with an unrealistic presentation and poor technical quality. This film was deemed a poor teaching aid.
Recommended Use: Although the film seemed to be intended for adult audiences, because of its shortcomings, it was recommended it not be used.

ADDICTION RESEARCH FOUNDATION **NEW RELEASES**

AUDIO CASSETTE PRESENTATIONS

AT-013 CHANGING THE DRUG DEPENDENT LIFESTYLE
21 minutes *by Anne McKay*
Lifestyle change is a difficult challenge facing alcohol and drug abusers. Anne McKay, formerly an occupational therapist with the Addiction Research Foundation of Ontario, discusses leisure related problems, leisure counseling, and the basics of a leisure service. Program planners, counselors, occupational therapists, and recreationists should find this information useful, not only in assisting alcohol and drug abusers but also in developing preventative mental health, pre-retirement, community re-entry, and other lifestyle change programs.

AT-014 SOLVENT AND AEROSOL ABUSE
25 minutes *by Alec Gabe, Frederick Glaser, and Adrian Wilkinson*
What are solvents and aerosols? Who abuses them and why? What can the community do about it? These questions and others are explored in a wide-ranging discussion including Mr. Alec Gabe, information counselor; Dr. Frederick Glaser, head of psychiatry; and Dr. Adrian Wilkinson, clinical psychologist; all with the Addiction Research Foundation of Ontario. Approaches to the management and control are presented along with a discussion of the evaluative process.

AT-015 DRINKING-DRIVING COUNTERMEASURE PROGRAMS
24 minutes *by Pamela Ennis*
The focus in this presentation by Dr. Pamela Ennis, a scientist with the Addiction Research Foundation of Ontario, is on drinking-driving countermeasure programs. Strategies of primary, secondary, and tertiary intervention are considered and their effectiveness is discussed in the context of general and specific deterrence.

OTHER CURRENT TITLES

AT-001 PREGNANCY AND DRUGS — *by Barbara Tucker*
AT-002 FAMILY THERAPY — *by Reesa Kassirer*
AT-003 WOMEN AND PSYCHOTROPIC DRUGS — *by Ruth Cooperstock*
AT-004 COUNSELLING THE CHILDREN OF ALCOHOLICS — *by Kathleen Michael*
AT-005 DETOX CENTRES — THE ALTERNATIVE — *by Dianne Hobbs*
AT-006 COCAINE — *by Oriana J. Kalant*
AT-007 CONTROLLED DRINKING CONTROVERSY — *by Norman Giesbrecht*
AT-008 THE WOMAN AND HAZARDOUS DRINKING — *edited by Deborah Levine*
AT-009 TEENAGE DRINKING: USE AND ABUSE OF ALCOHOL — *by Reginald G. Smart*
AT-010 EMPLOYEE ASSISTANCE PROGRAMS: An Overview for Employers — *by Bryan White*
AT-011 OUTPATIENT TREATMENT OF THE ADULT ALCOHOLIC — *by Michael Jacobs*
AT-012 DRUGS AND THE TEENAGER — *by Dana L. Farnsworth and Michael Jacobs*



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Coming Events

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Canada

The College Of Family Physicians Of Canada Annual Meeting — Sept 10-16, 1978, Charlottetown, Prince Edward Island. Information: Donald Rice, executive director, The College of Family Physicians of Canada, 4000 Leslie St, Willowdale, Ontario, M2K 2R9.

Alberta Alcoholism And Drug Abuse Commission Summer School On Alcohol And Drugs — Sept 22-23, 1978, Kananaskis, Alta. Information: Marg Bailey, AADAC Community Extension Services, 2nd floor, 812-16th Ave SW, Calgary, Alta, T2R 0T2.

The College Of Family Physicians of Canada (Ontario chapter) Annual Meeting — Oct 16-18, 1978, Toronto, Ont. Information: Marcia Barrett, 4000 Leslie St, Willowdale, Ont, M2K 2R9.

Canadian Psychiatric Association Annual Meeting — Oct 18-20, 1978, Halifax, Nova Scotia. Information: Dr A. Cote, secretary, Canadian Psychiatric Association, Suite 103, 225 Lisgar St, Ottawa, Ontario, K2P 0C6.

United States

Employee Assistance Programs In Institutions Of Higher Education — Aug 3-5, 1978, Kansas City, Missouri. Information: Employee Assistance Program, 205 Columbia Professional Building, Columbia, Missouri, 65201.

13th Annual Teenage Institute On Alcohol And Other Drugs — Aug 6-10, 1978, Granville, Ohio. Information: Elaine Zabor, Teenage Institute Director, Division of Alcoholism, Ohio Department of Health, PO Box 118, Columbus, Ohio, 43216.

National Association Of Alcoholism Counsellors Annual Meeting — Aug 11-13, 1978, Memphis, Tennessee. Information: Charles Hauff, NAAC vice-president, 2304 Hermitage Way, No 505, Indianapolis, Indiana, 46224.

1978 Summer Institute On Drug Dependence — Aug 27-Sept 1, 1978, Colorado Springs, Colorado. Information: Summer Institute, PO Box 2172, Colorado Springs, CL, 80901.

National Amphetamine Conference — Sept 16-17, 1978, San Francisco, California. Information: Stephanie Ross, Amphetamine Evaluation and Physician Training Project, 409 Clayton St, San Francisco, CA, 94117.

Alcohol and Drug Problems Association Of North America Annual Meeting — Sept 24-28, 1978, Seattle, Washington. Information: Lynn Buttorff, executive-assistant - to - director, ADPA, Suite 204, 1101 15th St NW, Washington, DC, 20005.

American Association For Automotive Medicine — Oct 3-6, 1978, Louisville, Kentucky. Information: AAAM executive secretary, PO Box 222, Morton Grove, Illinois, 60053.

Annual Psychotherapy Associates Fall Workshop On The Treatment And Rehabilitation Of The Alcoholic — Oct 1-6, 1978, Savannah, Georgia. Information: Dr Bernard M. McGahee, 12506 Cranwood Lane, Savannah, GA, 31406.

Association Of Labor-Management Administrators And Consultants On Alcoholism Annual Meeting — Oct 4-6, 1978, San Francisco, California. Information: ALMACA, Suite 907, 1800 N Kent St, Arlington, Virginia, 22209.

Youth, Alcohol, And Social Policy Conference — Oct 19-20, 1978, Arlington, Virginia. Information: Gail Dickerson, Program Director, Health Education Foundation, 600 New Hampshire Ave NW, Washington, DC, 20037.

3rd Southeastern Conference On Alcohol and Drug Addiction — Nov 29-Dec 3, 1978, Atlanta, Georgia. Information: Conway Hunter Jr, Medical Director, Addictive Disease Unit, Peachford Hospital, 2151 Peachford Rd, Atlanta, GA.

Abroad

32nd International Congress On Alcoholism And Drug Dependence — Sept 3-8, 1978, Warsaw, Poland. Information: International Council on Alcohol and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

3rd World Conference Of Therapeutic Communities — Sept 17-22, 1978, Rome, Italy. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Representation Of Alcoholism In Cinema And Television — Sept 25-29, 1978, London, England. Information: The Secretary, Representation of Alcoholism Course, Alcoholism Education Centre, The Maudsley Hospital, 99 Denmark Hill, London, SEA 8AZ.

International Symposium On Alcoholism And Drug Dependence — Oct 16-20, 1978, Sao Paulo, Brazil. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

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Advertising Rates:
a) Regular Line Rates 55¢ line
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Circulation: 10,019
(Ontario, 6,718; other provinces, 711; USA, 2,320, foreign, 270). Bulk, 3,000; Media 1,093

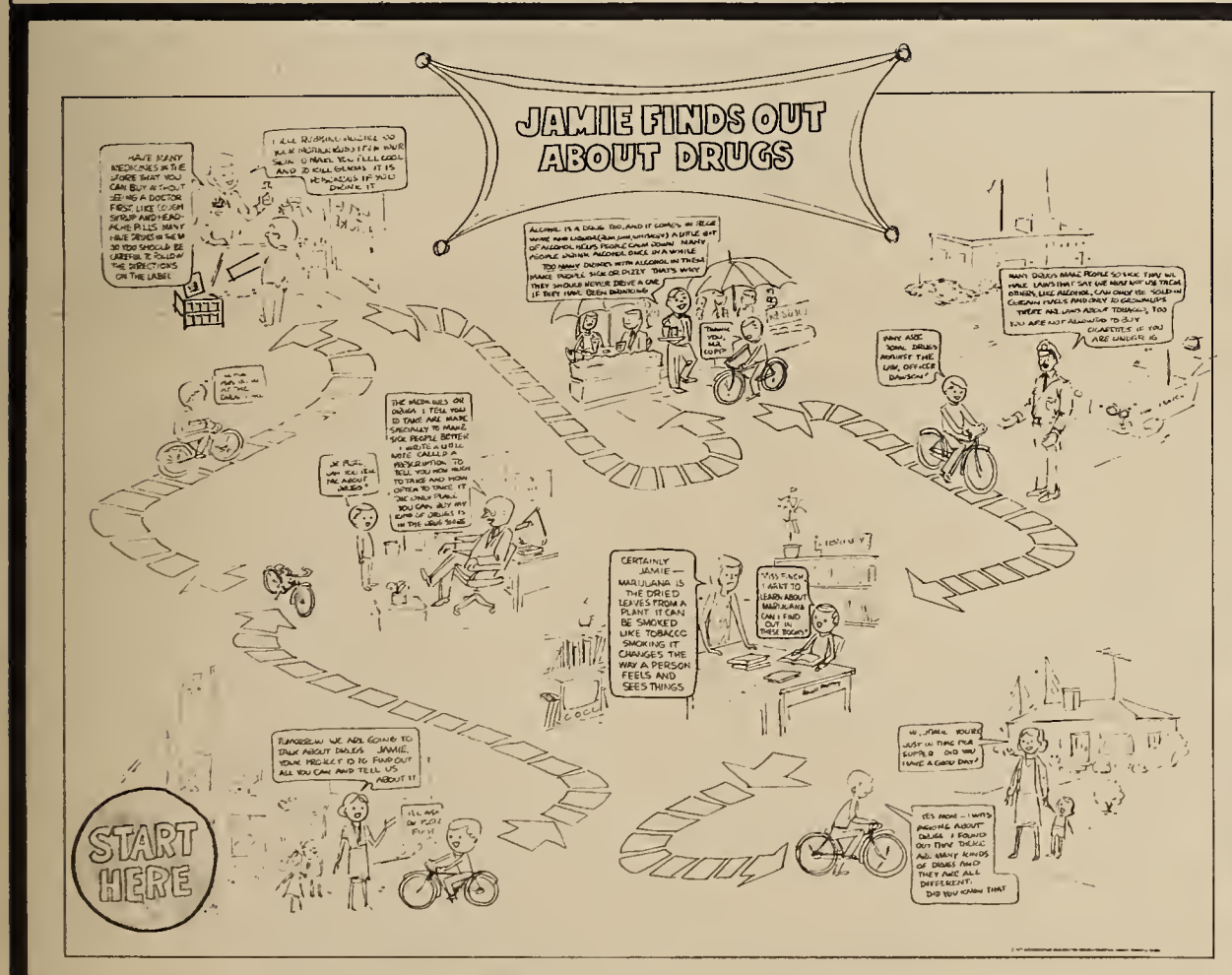
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Hard to spot and treat

Addictions an occupational hazard for MDs

By Betty Lou Lee

YOU KNOW there's one doctor among the 23 people listening to a talk on alcoholism at the Homewood Sanitarium in Guelph, Ontario. You also know the doctor is an alcoholic, because everyone in the group is, whether they've admitted it yet or not.

You play a guessing game and narrow the doctor down to one of two — the man with the rather regal bearing who doesn't join in the discussion, or the greying woman who seems vaguely embarrassed. You're wrong.

If it's hard to spot a doctor among a group of alcoholics, it's just as hard to spot an alcoholic among a group of doctors. But more Canadian medical associations and regulatory bodies are trying to reach and help addicted physicians before they reach the point where they endanger their licences — and their patients.

THE BACK PAGE

It's not an easy task. No one knows how many there are, but the guesstimates range from 5% to 10%. They tend to be 'loner' addicts, and they're adept at masking hangover symptoms with a chemical armamentarium.

Along with suicide, mental illness, and marital breakdown, addiction is considered an occupational hazard for physicians. Work-related stress is frequently mentioned as a major cause, but there are other factors more peculiar to the profession.

Because they have more technical knowledge of drugs and alcohol than lay people, doctors often believe they can use them with impunity, and too often follow a policy of Physician, Heal Thyself, when dealing with fatigue, insomnia, or frustration.

Doctors don't have to skulk through the street drug market.

They don't have to skulk through the labyrinth of the street-drug market.

While the tendency in the past has been for the profession to close ranks and indulge in a blanket denial of the problem until a doctor got to the stage that disciplinary action was necessary, now there's more emphasis on practising what it preaches — early detection, early treatment, and prevention.

The Saskatchewan Medical Association, with about 1,500 members, has one of the more highly organized programs. SPARC — Saskatchewan Physicians at Risk Committee — has worked with close to 20 doctors in the past two years.

The committee has up to 20 doctors who are recovered drug and/or alcohol abusers or who work in the addiction rehabilitation field, and they live in both urban and rural areas.

When a doctor comes to their attention, through self-referral, or information from a colleague, spouse, or hospital staff, a recovered doctor from the district visits to offer help, overcome denial, and get the doctor and the doctor's family involved in the most suitable treatment program. Efforts will be made to maintain the practice if treatment is needed.

"It's a non-punitive program with a humanitarian approach," says Tony Cosgrave, communications director with the SMA. "There's no sword of Damocles by the College of Physicians and Surgeons. The (college) registrar would rather see rehabilitation than a licence suspension."

SPARC doesn't rule out official college involvement, however. If a doctor refuses help or therapy, or fails to achieve some degree of rehabilitation after two attempts, he or she will be brought to the attention of the college's council, which can threaten suspension in order to get him to take treatment, or refer him to a mental health or discipline committee. His licence could be suspended for a set period, restricted, or modified to specific conditions under which he could practice.

"We're getting doctors earlier in their problem," Mr Cosgrave says, "but we find identification is still the big problem. Doctors tend to protect one another, spouses are reluctant to seek help, and nurses are reluctant to report a doctor.

"If an operating room nurse knows a surgeon didn't have all his faculties during an operation, and he's the only surgeon in town, she can be criticized if she reports him: 'Thanks a lot for losing us Charlie.' The public can also protect an addicted doctor, if he's the only one in town. They'd rather have one who's abusing drugs than none at all."

SPARC refers doctors who need clinic or hospital care to the Saskatchewan Alcohol Commission rehabilitation centres in Regina and Saskatoon, to Homewood in Guelph, or a centre in North Dakota. It works also with lay groups like Alcoholics Anonymous, Alateen, and Alanon, and provides support and assistance when the physician is getting reestablished after treatment.

Ontario, with 14,000 of Canada's approximately 32,000 practising physicians, has had a DOC — Doctors on Chemicals — program for more than a year, supported by the Ontario Medical Association, the Ontario College of Physicians and Surgeons, and the Addiction Research Foundation.

Doctors are coming forward voluntarily to seek treatment.

Its emphasis is on marshalling existing resources rather than setting up parallel programs of its own, early treatment, and education about the occupational hazards of addiction that would begin in medical school.

"There's been an increased number coming forward asking for help voluntarily, and an increased number of colleagues seeking help for someone they know is facing a problem," says William Henderson, deputy registrar of the College of Physicians and Surgeons. "It's one of the most rewarding and satisfying things I've done in a long time," he says of his involvement with the program.

He estimates that somewhere between 50 and 100 doctors have been helped in the past year.

"The biggest problem is one of attitude, the attitude that there's little you can do. It's not easy to come forward to talk about the problem. A doctor isn't allowed to fail. If he goes to a colleague, his relationship is one of colleague-ship, rather than patient-doctor. And doctors don't make good patients."

Dr Henderson said some have questioned the college's involvement in such a program, since its primary function is to serve the public interest and doctors might fear asking for help. He thinks there's a positive aspect, because the best rehabilitation results are being obtained with employer-coercion programs in other occupations.

'The only approach for rehabilitation is on a lifestyle basis . . .'

"I'm satisfied that the only approach we have for rehabilitation is on a lifestyle basis, and there must be a compelling reason to change a lifestyle."

The project has a 24-hour phone service (595-6288) for doctors seeking advice about addiction problems, and is working on establishing a cadre of "physician advocates." They would be doctors who have successfully fought the same battles and can bring their knowledge and understanding to support and encourage the doctor before, during, and after treatment. It has also been investigating the opportunities available for supervised work after treatment: situations where the doctor won't be solely responsible for patients.

Robert F. Clarke of Edmonton was appointed by the board of the 2,700-member Alberta Medical Association to assist doctors with addiction problems.

"A long time ago, there was a psychotherapeutics committee of the college to deal with emotional, drug, and alcohol problems. But it didn't work. Doctors don't go to committees, they want to pick their own therapist. So a couple of years ago the board appointed me to publicize that help was available, and get interested doctors in the communities to help me.

'I wouldn't allow a menace to continue practice. There's a need to protect the public . . .'

"The whole thing's confidential. I report to no one and the members know that. If they come to me, I refer them to treatment: some to physicians, some to clinics in Seattle or Chicago. But I wouldn't allow a menace to continue practice. There's a need to protect the public and I won't cover-up. He must work within his limitations."

Dr Clark won't say how many doctors have come to him, but says that addiction is "an important problem among doctors. There might be three times the alcoholism rate of the general population, and 10 times the drug abuse rate.

"But alcohol is usually the basic one. For one-third to one-half, there may be another drug. Ritalin is a common one, and Valium. But there's relatively small use of narcotics, considering their accessibility to doctors."

J. A. Hutchison of Vancouver, registrar of the British Columbia College of Physicians and Surgeons, examines about 15 doctors a year who have been reported for investigation of their fitness to practice because of emotional illnesses, including addiction. But he has no real idea how many of the province's 4,500 physicians abuse chemicals, and he points out some of the problems in finding them.

"You often find a doctor moving from province to province who's a potential problem. He may duck and run for cover while he can still get a certificate of good standing from the college of the province he's in.

'I think some doctors are addiction-prone and have to be watched for life . . .'

"And a doctor with a drug, alcohol, or emotional problem tends to gravitate to the geographic periphery, maybe because the cut and thrust of economic competition is too tough in urban areas, maybe because patients have drifted off because he's often not available, or maybe because he's having trouble with hospital privileges. On the periphery, he's unmolested, and he has a captive audience."

Although BC has a higher rate of drug abuse in the general population than the rest of Canada, he's unsure if this is true for doctors. In his experience, sedatives, narcotics, and a cycle of uppers in the morning, downers at night, are the common drug usage patterns.

One factor Dr Hutchison feels encourages doctors to seek help is a BCMA insurance program that covers income during illness up to $1,500 a month, so the doctor in addiction treatment has some money coming in. Local medical societies also have active physician-help committees.

Newfoundland's doctor population has almost doubled to 700 in the last five years, and the amount of addiction is a question mark. "Before the big increase, most of the doctors with problems were known," says Dr David Parsons of St John's. "But that didn't make it any easier to help. It's usually done on an individual basis, which isn't the best way, because when friends are involved, it's difficult to treat. In the last five years, I'd say we had five or six with serious problems."

Dr Jim Morison, registrar of the Manitoba College of Physicians and Surgeons, says the Manitoba Medical Association had the idea of maintaining a special apartment where a doctor could "dry out" without being seen — a common concern to physicians. "But they decided it was too expensive for the scope of the problem." About six doctors a year of the province's 1,700 come to the attention of the college because of chemical abuse.

He finds that getting supervised work for a doctor after treatment is a stumbling block to rehabilitation, and would like to see a 'buddy system' where another physician takes responsibility for supervision and reporting to the college. "I think some doctors are addiction-prone and have to be watched for life."

There have always been out-of-the way places where professionals, politicians, and celebrities could disappear to "take the cure." Homewood Sanitarium, although it treats the whole range of mental illness, has been such a haven since it was established in 1883 as "an asylum for the insane and inebriates."

With its Georgian pillars, sweeping lawns, tennis courts, bowling alley, and whirlpool bath, it has the reputation of being both toney and pricey, probably because it's a "private hospital." But in 1920, its rates were $2.10 a day, and its 1977 rates were about $10 daily more than Ontario Insurance Plan Health coverage.

Executive director, psychiatrist Merville O. Vincent, says it probably treats more addicted doctors than any other inpatient facility in the country. About 200 have come there from across the country in the 28 years he's been at the hospital.

"In general, they are tough to treat. It's hard for a doctor to shift roles, settle back and be a patient, because he's used to being the doctor. It's also hard for nurses and other doctors to treat him as a patient and allow him to shift roles. He tends to get too much VIP treatment, and they assume he knows things he doesn't, especially about himself.

"And the other patients don't allow him to be a patient. They find out he's a doctor, and come to him with complaints about the staff, with questions about their medication. Most patients get away from their basic occupational roles when they're in hospital, but doctors have a funny ambivalence. A doctor will say: 'Put me down as mister,' but almost invariably within 48 hours, he lets the other patients know he's a doctor, and it's more than just a slip. Because if he's not a doctor, he's an alcoholic."

Dr Vincent believes doctors often become alcoholics because they're also workoholics. "They get on a treadmill where they don't set up opportunities to unwind." If they see their role as stamping out disease, suffering, and death, they must also see themselves as failures. "The real role is to cure occasionally, but to be helpful and supportive always," says Dr Vincent.

"The sequelae of their role strain are despair, guilt, and fatigue as they spin their wheels faster. Then they treat themselves with alcohol and drugs."

One-third of doctor narcotic addicts shake their addictions.

Doctors on drugs "get frightened when they get hooked, because they see the general cure rate is 5% to 10%, and they think they don't stand a chance". Actually, they do much better at rehabilitation than the general population, he says. One-third of doctor narcotic addicts shake their addiction completely, another third show marked improvement with treatment.

This optimism about treatment outcomes, once the formidable obstacles to getting into treatment are overcome, is reflected in other studies around the continent.

If their practices can be kept intact until they are able to return to work, doctors retain their good incomes, and privileged status in the community.

It may well be that this successful group will supply the bulk of support and treatment services to the growing number of addicted doctors seeking help.

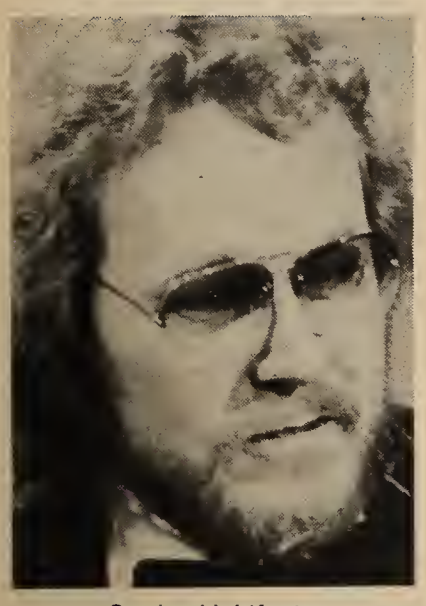
alcoholism and drug research

Vol. 7 No. 9 TORONTO September 1, 1978

PERIODICALS READING ROOM
Humanities & Social Sciences
LIBRARY OCT 4 1978 University of Toronto

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems



Gordon Lightfoot

Singer sparks breath test debate

By John Shaughnessy

TORONTO — The acquittal of Canadian folk hero Gordon Lightfoot on a drinking and driving charge here could kill the use of breath sample evidence in many Canadian courtrooms.

Earlier this year, the prominent singer and composer was charged with driving with a blood alcohol level in excess of the legal 0.08%. At his trial last month, police officers testified he was stopped because he was driving with the high beams of his car on, that he failed a breath test on an ALERT — the device approved and used in most provinces to spot possible drinking drivers — and that about one hour later official tests on a Breathalyzer at a police station showed his BAL was 0.12% and 0.11%.

Provincial Court Judge S. M. Roebuck ruled this evidence was not sufficient to prove Mr Lightfoot's blood alcohol level exceeded the legal limit at the time he was driving, and acquitted him.

Deputy Crown attorney, Norman Matusiak told the judge it was natural and logical to infer from the official readings that Mr Lightfoot's BAL exceeded 0.08% when he was driving but the judge disagreed, saying he needed medical evidence to satisfy himself that he could draw such an inference.

The judge said that "based on the evidence I have heard there is nothing relating the readings to the amount of alcohol he had at the time he was stopped. Based on the evidence the court dismisses the charge."

Immediately after the acquittal, Mr Matusiak told reporters the decision "has shot the whole roadside screening program . . . It opens a hole in the line you could drive a truck through." He said similar cases awaiting trial may have to be adjourned until an appeal court makes a ruling on the Lightfoot decision.

Al Nield, a community consultant with the West Metro Centre of the Addiction Research Foundation in Toronto, told **The Journal** that the decision, if upheld on appeal, would effectively outlaw breath tests — "there'd be no point in using them" — and would bring into question how impaired drivers could be apprehended at all.

"As things now stand, the Breathalyzer is the only mechanism that is acceptable in court. You have to ask the apprehended person's permission to take a blood sample, but you don't have to ask permission to take a breath sample. The ALERT device (Alcohol Level Evaluation Roadside Tester) gives a pass, fail, or warn reading, but test results are unofficial and are not accepted as evidence in court."

Mr Nield, one of the originators of the RIDE program (Reduce Impaired Driving in Etobicoke) (See page 3) said the decision could mean that in every prosecution for impaired driving, medical evidence would have to be presented to draw inferences from the BAL levels on the breath tests and the BAL levels at the time the accused was driving, or the police would simply lay no more charges (until they get the go ahead or until new legislation is passed).

What the Criminal Code says . . . page 3

Meanwhile, police are ignoring the Lightfoot decision. Jack Ackroyd, deputy chief of the Metropolitan Toronto Police Department told **The Journal**: "We're just going to carry on until the appeal is heard.

"It's my opinion that the judge erred in law, and that's why we'll have to appeal it," he said.

The judge refused to draw the inference but "as long as the accused is in police custody there's no way he could have been drinking from the time he was first picked up and the final Breathalyzer."

Sergeant Don Colbourne, coordinator of the RIDE program said the decision "hasn't affected our procedures one iota. One judge's decision is not binding unless it's upheld on appeal. Until that happens we'll continue as normal."

Non-Mudd gives way to health promotion

OTTAWA — The federal government's Non-Medical Use of Drugs Directorate (Non-Mudd) has been caught in a major reshuffling of health services.

As a result of the reorganization, announced in late July, Non-Mudd will be under the Health Services and Promotion Branch of the department of national health and welfare. The branch will be headed by assistant deputy minister, Dr Maureen Law.

Ron Draper, former director general of Non-Mudd, is now director general of the Promotion and Prevention Directorate. In addition to Non-Mudd activities, this directorate will have responsibility for programs involving cardiovascular disease, nutrition, health promotion, lifestyle, and family planning.

Evelyn Pagé, administrative assistant to Mr Draper, told **The Journal** she didn't know how the reorganization would affect existing funding arrangements for Non-Mudd programs.

"Even without the reorganization, the government had announced financial cutbacks," she said.

"From the start Non-Mudd programs have been experimental. The federal government carried the financial responsibility for a maximum of three years, and then if the programs were continued, the provinces took over."

Under the new scheme, Mr Draper will be one of three directors general reporting to Dr Law as head of the Health Services and Promotion Branch. In addition to the director general of the Promotion and Prevention Directorate, there will be directors general of Health Services and of Policy Coordination and Education. A director of Financial and Management Services will also report to Dr Law.



Canadian Health Minister Monique Begin has taken the first steps to open controversial files on drug users to public scrutiny. Page 2.

$68 billion for drug ills

WASHINGTON — A new and vigorous prevention strategy is essential against smoking and alcohol abuse, which is involved in much of the death rate in the United States from circulatory disease, accidents, and cancer, says Joseph Califano, secretary of health, education and welfare.

Overall, the two diseases, and accidents, cause 76% of all deaths annually. On an economic level, smoking and alcohol abuse account for between $61 billion and $68 billion annually in health costs, lost earnings, absenteeism, and accidents.

Mr Califano said the US spends more than almost any other industrial nation on health care, yet the return in better health has been modest. Spending is

(See — No. 1 — page 4)

We can drive, say drinkers

HAMILTON — More than two-thirds of impaired drivers surveyed in Etobicoke, Ont, where singer Gordon Lightfoot was charged, thought they could drive as well in their present condition as they could when they were sober.

The average blood alcohol level of the 129 drivers was .14%, almost twice the legal limit of 0.08%.

Almost 70% had heard of RIDE, a program of police spot checks to catch impaired drivers (See page 3) but 30% felt they had a right to drive while under the influence; 26% thought they were all right to drive; and 16% said they trusted to luck.

Twenty per cent said no one else was available to drive; 10% said they had to drink and weren't concerned about consequences; and 3.5% said they had an alcohol or personal problem.

Client rights — Can dignity be preserved? . . . page 9

Begin's drug files: Open and shut case?

By Bryne Carruthers

OTTAWA — As promised, Federal Health Minister Monique Begin has taken the first steps to open to public scrutiny her department's controversial files on known and suspected drug users and distributors in Canada.

However, government bureaucrats are now trying to figure ways for the information to be made available to those Canadians named in the files without risking the information's being seen inadvertently by others.

A spokesman for the minister explained that in the case of drug files containing sensitive information, "we would want the file to pass through as few hands as possible," even within the government.

At the same time, some procedure for ensuring that only the proper individuals see the files — that is, the named individuals and no one else — must also be developed. The most likely is some requirement that the individual appear at a government office and provide acceptable identification before a drug file is turned over. This limits use of the mails.

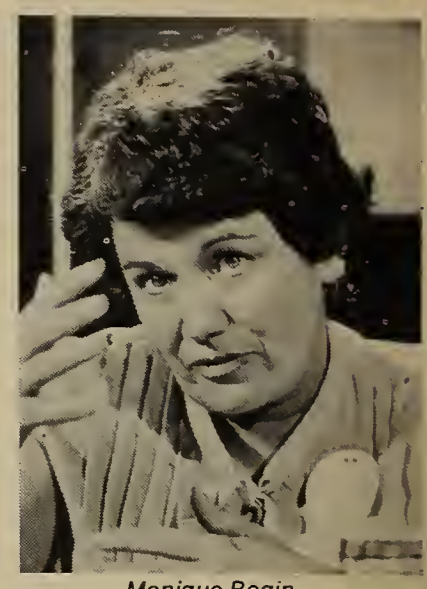
The problem, while not unique within the government now that thousands of government files are available for inspection by named individuals under the privacy provisions of the Human Rights Act, could be worsened if a large number of requests to see files is received once the new cabinet order is passed.

In fact, there are rumblings already within the health department that a shortage of manpower to screen such requests, vet sensitive information from some of the files, and arrange for the files to be transmitted to the interested individuals, could very well delay handling of such requests.

In other words, there are already warnings emerging that even when the drug files are open to public scrutiny, it's going to be a battle to get to see what the government has on one out of every 100 Canadians who are listed as known or suspected drug users.

While Health Minister Begin has already signed a new cabinet submission requesting that an earlier federal eabinet order be rescinded, at press time the federal cabinet had still not approved the replacement cabinet order that will allow named Canadians to see what's in their drug files, subject to some discretionary editing by the minister.

The minister will have the power to delete information on other people and on matters that might jeopardize ongoing criminal investigations. However, the government will have to notify the person requesting to review the drug file that information has been deleted. And the Human Rights Act provides for appeals to the privacy commissioner if the individual believes some information has been incorrcetly withheld.



Monique Begin

This compares with the previous situation, whereby the whole data bank on drug users and distributors was closed to any public scrutiny and no appeal was readily available. In fact, under the original cabinet order now in the process of being replaced, the government was refusing to admit even that files existed on specific individuals.

The health minister agreed to open up the drug files after a lengthy investigation by **The Journal** revealed a complete closure was unjustified under the spirit of the Human Rights Act and some of the same information was available from RCMP files under the same Act.

Individuals wanting to see what the government has on them will have to wait until the new cabinet order is published in the official Canada Gazette — a process that usually takes several weeks and therefore should have happened by mid-September. Another notice is also being prepared to modify the official listing of data banks under the Human Rights Act; that notice will provide details on how individuals can apply to see their files.

The agency handling the requests is the federal bureau of dangerous drugs, federal health protection branch, department of national health and welfare, Ottawa.

Canadian Forces alcohol use

Lifestyle helps and hinders

OTTAWA — The seven-year-old drug and alcohol program (DAP) of the federal department of national defence boasts a 66% alcoholism recovery rate. And a "more controlled environment" is part of the reason, says Lt-Col John Harder, DAP's outgoing coordinator.

That same environment, however, may be one factor driving enlistees to addictive drinking, he concedes.

Lt-Col Harder left the DAP in August to become head of the Canadian Forces' social development services. Major Paul Langevin replaces him.

Lt-Col Harder told **The Journal** that in the environment of a Forces base (CFB), residents "play together, they work together, they socialize together.

"For identifying a problem . . . we consider that to be a distinct advantage."

But, "in particular social environments" where individuals are separated from their families or serving in isolated or foreign locations, "people tend to drink more," he said.

For the 1% of Canada's 300,000 military and civilian forces personnel who, according to department estimates, become overly involved with alcohol in any given year, the choice is clear.

"The Canadian Forces recognizes alcohol dependence as a treatable disease, and will assist its members in obtaining treatment as for any illness," according to DAP's introductory visual presentation.

However, "refusal to accept treatment for a condition which is causing substandard performance will result in release from the forces."

The "emphasis is on performance," Lt-Col Harder said. "If a person's drinking or his refusal to accept help . . . interferes with his performance, then we can no longer use that individual."

The department considers a person is misusing alcohol if drinking interferes with work performanee, creates an administrative or domestic burden, impairs his/her social or eeonomic function, or discredits the Canadian Forces.

"We believe our people are involved to a much lesser degree, because of our policies," Lt-Col Harder said.

Although some offenders may go undeteeted, there is "very little evidence of prolonged heavy use of even cannabis . . . When there is, we view this rather seriously and people are appropriately dealt with."

Lt-Col Harder identified two ideal stages for stemming an individual's progression to alcoholism. He pointed to evidence of family difficulties and more frequently, of employment difficulties, as the best times "to coerce him into treatment."

At these stages, a person is experiencing problems, but "still has some important values left," Lt-Col Harder said.

DAP's three steps are prevention as "highest priority," efficient and realistic "management of offenders and casualties," and rehabilitation and treatment, he said.

Alcohol "produces by far the greatest number of easualties," followed in priority by tranquillizers and barbiturates; hallucinogens ineluding cannabis; and "isolated amphetamine and opiate use."

Case closed on Bourne

WASHINGTON — The legal file on Peter Bourne, former special adviser on health issues to United States President Jimmy Carter, has been closed.

Dr Bourne resigned in mid-July after public disclosure that he had written, for an aide, a prescription for the controlled drug methaqualone (Quaalude) (**The Journal**, August). The 38-year-old psychiatrist used a pseudonym to protect the aide's confidentiality.

Prosecutor Paul Ebert of Prince William County, Virginia, where an attempt to fill out the prescription was made, said no criminal charges will be made against Dr Bourne in the county or in Washington, following investigation.

Interviews with Dr Bourne and his aide convinced the prosecutor "Bourne had no knowledge the prescription was to be passed in Virginia."

Alice in Courtland: Caught in a secret file

By Wayne Howell



A Cheshire cat, a mad tea party, a lobster that could dance the quadrille; what strange sights Alice had seen since she had followed the mysterious white rabbit down a hole. And now she was approaching what appeared to be a courthouse. You can imagine her surprise when she was greeted al the door by the elusive white rabbit himself, still wearing his waistcoat and gold watch but now also wearing black barristers' robes.

"Come Alice, let me show you around," he said, taking her by the arm and leading her into one of the courtrooms. But the room was empty save for a disconsolate looking caterpillar in the prisoner's dock; it was the hookah-smoking caterpillar she had met in chapter five.

"Why I know him," exclaimed Alice. "He told me the most delightful poem, and he gave me a bite of his mushroom and then I felt like I was changing size. What is he doing here?"

"This is known as the Court of Discretion," said the White Rabbit.

"But where is the court reporter, the judge, the jury, the bailiff, the defence counsel . . . . .?"

"I am all those things," said the White Rabbit. "As a matter of fact, court is now in session!"

"I didn't hear any gavel fall," protested Alice.

"I do it all in my head. You see, your friend the caterpillar was apprehended sneaking into Wonderland with 25 ounces of hash oil secreted in the bottom of his valise. His conviction is a forgone conclusion, but first I must decide what he is to be convicted of. I might want to charge him with Importing and see him get seven mandatory years in the slammer. Or, I might want to charge him with Possession for Purposes of Trafficking so he can get off with as little as 90 days."

"How do you decide?"

"That depends on a lot of things — like which side of the bed I got up on in the morning, whether I like his looks, whether my lunch agreed with me. In this case I think I'll put him away for seven because I don't particularly care for caterpillars — kind of sleazy you know, always creeping and crawling around."

"But they do become beautiful Monarch Butterflys," said Alice.

"They do? I didn't know that caterpillars were part of the Monarch Butterfly family. Well now, that does make a difference. Oh my yes."

"Why does it make a difference?" asked Alice, by now quite confused.

"Because in the prosecutor's Court of Discretion, certain people are allowed to commit indiscretions," said the White Rabbit. Aliee didn't understand but before she could ask for a rational explanation, the White Rabbit had whisked her out of the courtroom (apparently court was no longer in session — it was hard to tell because the White Rabbit held it entirely in his own mind) and into another courtroom. This one was jammed with spectators and Alice recognized the Mad Hatter sitting in the jury box gossiping with the Mock Turtle who was apparently acting as bailiff. Before she knew what was happening, the White Rabbit had lead her into the prisoner's dock.

"What courtroom is this?" cried Alice with alarm.

"This is the Court of Private Punishments. Did you not admit that you knew the accused and sampled his wares on al least one occasion?" asked the White Rabbit.

"But you have no case against me," said Alice.

"Of course we have no legal case against you. But this is the Court of Private Punishments, which is entirely divorced from due process," said the White Rabbit. He turned to the jury.

"What shall we do with her?" he asked.

"Let's open a file on her," suggested the Mad Hatter.

"A secret file," chimed in the March Hare.

"If she were a school prineipal we could demote her," said the Mock Turtle.

"If she were an immigrant we could keep her out on grounds of moral turpitude," said the Walrus. The Carpenter agreed.

"Mâybe we could deny her life insurance; maybe we could keep her out of certain occupations . . . . ." Everyone was shouting suggestions. Alice started to cry.

"I've got it," shouted the judge, who was none other than the old Duchess. "She said she took the drug; let's send her over to the Court of Summary Treatment and make her prove she isn't addicted to it. Look at her sniffling and rubbing her nose and carrying on. I know *those* signs. It's the Court of Summary Treatment for the likes of her. They'll straighten her out whether she wants it or not, even if it takes them three years." The jury cheered so loudly even the Dormouse — who had been sleeping with his head in a teapot — raised his head and peered about with groggy eyes. Alice covered her face with her hands. And when she removed them she found herself looking at the blue sky of a summer's day. The river flowed slowly by, just as it had before she had fallen asleep.

"What a curious dream I had," she said to her sister. "Of course, it could never happen."

(Wayne Howell is an Ottawa physician and freelance writer.)

RIDE program cuts drinking accidents by 20%

By Betty Lou Lee

HAMILTON — A concentrated campaign against drinking and driving in a Toronto suburb has not only brought about a sharp reduction in alcohol-related accidents, but has also had an impact on drinking behavior in the community.

RIDE (Reduce Impaired Driving in Etobicoke) was started as a year-long pilot project in October 1977 in the borough of 300,000 people. (**The Journal**, Nov 1977).

By August, it had reduced drinking and driving accidents by 20%, and hotel owners, who originally were unhappy about it, are reporting positive effects. As they feared, they aren't selling as many drinks to customers, but more patrons are renting rooms for the night after drinking, rather than face the possibility of being caught in a spot check. And there are fewer fights and brawls, with the ensuing mess and damage to clean up.

One hotel reports frequent use of its coin-operated breath testing machine. It has trained its doormen to offer to call taxis for patrons who seem impaired and offer them free over-night parking. Bar tenders report more people are leaving their car keys with them.

One woman called the program to say it was the first time in years her husband had been home on time to have dinner with the children.

A wine-tasting club holds its meetings above a subway station, and advises its members to use public transit.

Couples decide whose turn it is to drive, and whose to drink, before leaving for a party. At least one convention arranged for sober drivers for partying delegates.

The program is sponsored by the Metro Toronto Police Department, the Etobicoke Safety Council, and the Addiction Research Foundation. It started with a public education campaign that tried to reach every home, with pamphlets and other information about RIDE, including the penalties for impaired driving, its cost to the individual and the community, and how to be a responsible host.

Specially marked cruisers rotate through 100 high-risk locations in the borough, conducting random spot checks. Any driver with the smell of alcohol on his breath is told to blow into a portable roadside breathtesting machine. If he's well below the legal limit, he's allowed to go, with a warning about drinking and driving. If he appears to be above the limit of 0.08%, he's taken to the police station for a regular Breathalyzer test, which can be used as evidence.

Results of RIDE were presented at the 19th annual Institute on Addiction Studies by Allen Nield of the Etobicoke branch of ARF and Sgt Donald Colbourne of the Metro police traffic division. The institute is held at McMaster University by Alcohol and Drug Concerns Inc of Don Mills, Ont.

By Aug 16, 124,742 cars had been stopped, and 1,684 drivers took the roadside test. Drinking-driving charges were laid against 458.

But in addition, the police found 59 people driving while under suspension, and 418 people for whom there were outstanding warrants. They issued 3,047 summonses under the Highway Traffic Act, arrested 70 people for offences not related to alcohol, and ordered 257 owners to have their cars examined for road worthiness. Another 2,663 drivers were ordered to have minor defects corrected within 48 hours.

Sgt Colbourne said some form of RIDE will be adopted throughout Metro Toronto (the name will be changed to Reduce Impaired Driving Everywhere).

Mr Nield said a package of audio-visual and print information material on how to set up such a program is expected to be ready by January to help other communities. Already, the program administrators have received requests for information from as far as New Zealand.

He attributed RIDE's success to the high level of public awareness of it. It has made people feel their risk of being caught is high if they drink and drive.

In one six-month period before RIDE, 10.06% of all accidents were alcohol related. In the same period a year later, this had dropped to 8.2%. (The rates remained the same for both periods in another borough on the other side of Metro.)

What the Criminal Code says:

The Lightfoot case



By John Shaughnessy

John Shaughnessy, contributing editor to **The Journal**, and a recent graduate of the University of Toronto Faculty of Law reviews Canadian breath testing legislation.

Under Canada's Criminal Code there are two main drinking and driving offences — driving while ability to drive is impaired, and driving with a blood alcohol level in excess of 0.08%.

No specific blood alcohol level need be proved to support a conviction for driving while impaired. Offenders are defined as *"every one who, while his ability to drive a motor vehicle is impaired by alcohol or a drug, drives a motor vehicle or has the care or control of a motor vehicle, whether it is in motion or not."*

People guilty of the second offence are those who drive a motor vehicle or have the care and control of a motor vehicle, whether it is in motion or not, having consumed alcohol in such quantity that the proportion in the blood exceeds 80 milligrams of alcohol in 100 millilitres of blood i.e. 0.08%.

All provinces, except British Columbia, Prince Edward Island, and Quebec, allow police to conduct roadside testing, to demand that a driver *suspected of having alcohol in his body* **provide a sample of his or her breath.**

The Criminal Code reads: *"Where a peace officer reasonably suspects that a person who is driving a motor vehicle or who has the care and control of a motor vehicle, whether it is in motion or not, has alcohol in his body, he may, by demand made to that person require him to provide forthwith such a sample of his breath as in the opinion of the peace officer is necessary to enable a proper analysis of his breath to be made by means of an approved roadside screening device, and where necessary to accompany the peace officer for the purpose of enabling such a sample of his blood to be taken."*

The approved roadside screening device is the Alcohol Level Evaluation Tester (ALERT) Model J2A-1000.

In addition, across Canada, where a peace officer "on reasonable and probable grounds" believes a person is committing, or within the previous two hours has committed, either of the two major drinking and driving offences, he may *"by demand of that person forthwith or as soon as practicable require him to provide then or as soon thereafter as practicable, such samples of his breath as in the opinion of a qualified technician are necessary to enable a proper analysis to be made in order to determine the proportion, if any, of alcohol in his blood, and to accompany the peace officer for the purpose of enabling such samples to be taken."*

Where breath samples have been taken under this section, the code states that if:

"(A) each sample was taken as soon as practicable after the time when the offence was alleged to have been committed and in any event not later than two hours after that time with an interval of at least fifteen minutes between the times when the samples were taken;

(B) each sample was received from the accused directly into an approved container or into an approved instrument operated by a qualified technician; and

(C) a chemical analysis of each sample was made by means of an approved instrument operated by a qualified technician; evidence of the results of the chemical analyses so made, is, in the absence of any proof to the contrary, proof that the proportion of alcohol in the blood of the accused at the time the offence was alleged to have been committed was:

(1) where the results of the analyses are the same, the proportion of such analyses and

(2) where the results are different, the lowest of the proportions determined by such analyses."

Instruments approved for the taking of these official tests are the Intoximeter Mark II, and Borkenstein Breathalyzer models Rex, RFL, 800, 900, and 900A.

A certificate by a qualified technician stating that proper procedures have been followed, the time and place the samples were taken, the results of the analyses, and that they were taken by him is "evidence of the statements contained in the certificate."

Alcohol lessons help shape students' values

TORONTO — Results of an experimental alcohol education program for students here justifies its wider use in Ontario schools, according to Addiction Research Foundation of Ontario scientist Michael Goodstadt.

An evaluation of the alcohol "lessons" given to students in the experiment found that boys in grades seven and eight who did not drink had attitudes less favorable to alcohol and its use following the lessons.

The lesson plans were developed at ARF following a request four years ago from the Toronto Board of Education to Dr Goodstadt for assistance with a new alcohol education curriculum.

Two sets of lesson plans — one for grades seven and eight, the other for grades nine and 10 — were written by Dr Goodstadt, Marg Sheppard, and Susan Crawford of ARF.

Lessons covered a wide range of topics relating to alcohol. A total of 952 students from grades seven and eight and 582 from grades nine and 10 took part in the experimental classes. A further 316 grades seven and eight, and 100 grades nine and 10 students acted as controls. Eight elementary and eight secondary Toronto schools participated in the study.

Other results of the program evaluation showed that:

- The lessons were well received by both students and teachers.
- The programs at both the elementary and secondary levels increased the level of knowledge of those exposed to the programs.
- The programs had no effect on the attitudes of female students.
- Among male students who did drink, both programs produced attitudes more favorable to alcohol.
- The elementary school's program was associated with less reported alcohol use among typical "non-drinkers" at the time of the post-test.
- The secondary school's program was associated with less reported alcohol use among "drinkers" at the time of the post-test.
- The elementary school's program had no effect on expectations concerning future use of alcohol.
- The secondary schools program was associated with an expectation that alcohol would be used less in the succeeding 12 months; this was found for both male drinkers and for females who usually did not drink.

The Ontario Ministry of Education has approved the lessons, and most Ontario schools have the programs available for use this school year.

Ms Sheppard, a senior research assistant and former teacher, told **The Journal**: "They are not the holy bible, but we suggest teachers try the lessons once and adapt them to their own teaching style and students needs . . . The lessons are not abstinence oriented, but give students the chance to come to conclusions about what type of behavior (concerning alcohol) is appropriate for them. It (the program) provides an open forum for kids to talk and hear what their parents, peers, teachers, and society are saying."

Yedy Israel to head Clinical Institute

TORONTO — Yedy Israel has been appointed director of the Clinical Institute at the Addiction Research Foundation of Ontario.

The 39-year-old biochemist and pharmacologist succeeds Dr James Rankin, director of the institute for the past eight years.

Dr Israel, noted for his research into alcohol-induced liver disease, told The Journal:

"We have excellent people in treatment and in research and we want to make sure the two groups work as one."

Dr Israel's association with the Addiction Research Foundation goes back to 1962 when he came from Chile with the aid of an ARF Fellowship to work on a PhD program in biochemistry and pharmacology at the University of Toronto under Dr Harold Kalant. He received his PhD in 1965 and was the recipient of the University of Toronto's Reeve Award for research in alcoholism.

The following year he worked as an International post-doctoral fellow at the National Institute of Health in Bethesda, Maryland. From 1966-70 he taught biochemistry at the University of Chile in Santiago, and while there was supported by grants from the ARF.

Dr Israel returned to Toronto in 1970 in the dual role of associate professor of pharmacology at the University of Toronto, and a scientist in the research division of the ARF. In 1974 he was made a full professor of pharmacology. Last year he was named head of the newly formed biochemical pathology section at the ARF. From 1974 to 1977, he was the recipient of a special liver project grant from the ARF and was senior investigator for experimental studies on alcohol-induced liver disease.

Correction

Merville O. Vincent, executive director of Homewood Sanitarium, has been associated with that institution for 18 years, not 28 as reported in **The Journal**, Aug. (Addictions an occupational hazard for MDs).

Women smokers and health: A long way, baby?

By Harvey McConnell

WASHINGTON — American women have adopted smoking habits more like men's and are now suffering almost similar rates of health problems.

In the past decade they have become more vulnerable "not only to lung cancer and other smoking related diseases, but also to specific health problems that are unique to their sex," according to a report, *The Health Consequences of Smoking*, issued by the department of health, education, and welfare.



Joseph Califano

'Women are taking up the habit at an earlier age and have become heavier smokers . . .'

The report, which has been submitted to Congress, has drawn on the latest research findings, much of it carried out in Britain and Canada, on the effects of smoking among women.

It points out that in the past women tended to smoke fewer cigarettes, were less likely to inhale, and were more likely to use filter-tipped brands. Today, "women are taking up the habit at an earlier age and have become heavier smokers."

The report summarizes the smoking-related problems unique to women:

- A strong, probably causal, association exists between cigarette smoking and higher late fetal and infant mortality among smokers.
- Perinatal mortality increases significantly with smoking, as well as with other risk factors such as maternal age, parity, socio-economic status, previous pregnancy history, and hemaglobin level.
- A dose-response relationship exists between smoking and incidence of low birth weight, preterm delivery, perinatal mortality, abruptio placentae (premature detachment), placenta previa (development in the lower uterus), bleeding during pregnancy, and prolonged, or premature rupture of the membranes.
- There is an association between smoking during pregnancy and impaired physical and intellectual development in the offspring.
- Carboxyhemaglobin levels are substantially elevated in pregnant women who smoke and may result in damage to placental and fetal blood vessels.
- Higher levels of carboxyhemaglobin in both fetal and maternal blood may be a factor in the increased incidence of low birth weight babies among smokers.
- The use of oral contraceptives potentiates the harmful effects of smoking on the cardiovascular system.
- Nicotine is present in the breast milk of lactating mothers who smoke, and has been shown to cause nausea, vomiting, diarrhea, and tachycardia (increased heart rate) in infants.

The report said that as recently as 1975, the last study of its kind carried out, 40% of the women in the US were not aware of the hazards to the developing fetus if they smoked during pregnancy.

In a summary of overall mortality among men and women, the rates for cigarette smokers are about 70% higher than those for non-smokers, the report said.

Overall mortality risk increases with the amount smoked: the risk of premature death in those who smoke 40 cigarettes a day is approximately twice that of non-smokers.

'Former smokers have lower mortality rates than smokers . . .'

The overall mortality ratios of smokers compared with non-smokers are highest at an earlier age and then decline. At age 40, the risk of premature death is twice as high among smokers.

The age at which smoking starts is another factor. For those who begin smoking before the age of 15 the risk of premature death is about 86% higher than that for non-smokers.

There is a 15% reduction in overall morality risks for smokers of low tar and nicotine cigarettes.

However, even among the low tar and nicotine smokers, their overall mortality rates are some 50% higher than for non-smokers.

Time does help: after 15 years off cigarettes the death rates for former smokers are nearly identical to those of non-smokers.

Regardless of the length of time they smoked, or the number of cigarettes smoked, former smokers have lower mortality rates than those who continue to smoke.

A positive dose-response relationship exists between cigar smoking and mortality. One study found it 39% higher than in non-smokers among men who consumed nine or more cigars a day.

The report said overall mortality ratios for pipe smokers are only slightly higher than for non-smokers.

Joseph Califano, secretary of HEW, said in a letter to Congress, that based on the report, he will submit within a year a legislative package in a bid to deal with the problems.

No. 1 prevention program should hit smoking: Califano

(from page 1)

focused almost obsessively on illness and treatment.

Prevention programs have succeeded in the past with communicable diseases: they make medical and economic sense, and they offer a way to foster good health with minimum intervention by government or the health care field.

The most important prevention program must be aimed at smoking "which we have identified as America's preventable public health enemy number one," Mr Califano told a joint conference on health strategies organized by Senator Edward Kennedy and the American Medical Association.

Moves have been made already including establishment of an Office on Smoking and Health; enlistment of the Public Health Service and Office of Education in new educational efforts; stepped up research into the health consequences of smoking; and the scheduling of a new Surgeon General's report on smoking and health to be published in 1979.

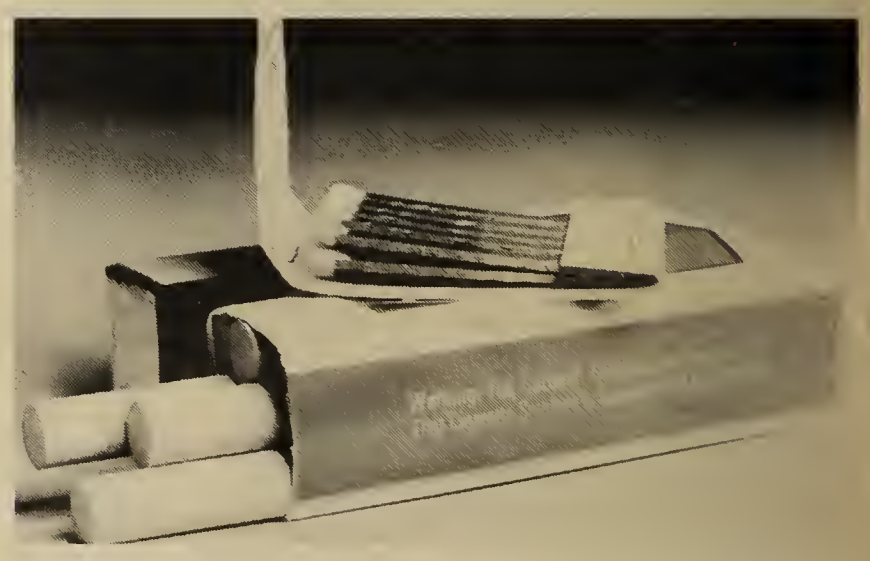
Mr Califano said the report on The Health Consequences of Smoking which he has submitted to Congress outlines the latest research data, especially the consequences of smoking among women.

"It confirms that women smokers, indeed, have 'come a long way, baby' — a long way toward higher disease and death rates from bronchitis, emphysema, lung cancer, certain other cancers, and cardiovascular disease.

"Since 1950, the death rate from lung cancer among men aged 45 to 64 has more than doubled. But among women, it has quadrupled. Seventy-five percent of heart attacks among women under age 45 could be avoided if women did not smoke."

Mr Califano added that figures show increased mortality and morbidity among women smokers who use oral contraceptives.

In this decade, studies have shown "probable cause and effect association between cigarette smoking and higher rates of late fetal and infant mortality."



Mr Califano said smoking and alcohol abuse must be included in all general health preventive strategies in the areas of education, delivery, and research.

"Disease prevention and health promotion in the future will challenge each of us to replace our prevailing ethic of expensive self-indulgence with an ethic of rigorous personal responsibility; to forsake habits that seem pleasurable, but are ultimately self destructive, in favor of habits that are prosaic but life saving," Mr Califano said.

"Exercise, for example, proper diet, and non-smoking ... Government cannot force it; doctors cannot administer it like a drug. We can only choose it for ourselves."

health strategies organized by Senator Edward Kennedy and the American Medical Association that within the confines of a society which offers a reasonable position about freedom of choice and goals in life, "you can give them guidance and information. Then you have to let them proceed at their own pace."



Quitters must quit alone

WASHINGTON — A majority of cigarette smokers are aware of the ill effects of their habit, but they must be allowed to proceed at their own pace in trying to stop, believes Joseph Cooper, dean of Cornell University Medical College.

Dr Cooper said: "I think there is all kinds of evidence and it all comes out bad. Practically all smokers know that."

He told a joint conference on

Tobacco lobby gets own way

WASHINGTON — A powerful, two week lobbying effort by the Tobacco Institute (an organization of cigarette companies) has caused the District of Columbia City Council to put aside an anti-smoking bill.

The council, after removing some of the more controversial parts of the original bill, by a voice vote had agreed to adopt it (The Journal, August). But at a formal vote two weeks later, the members voted seven to six to put it aside.

The action means it will now take a majority council vote to revive the measure, which appears highly unlikely.

During the two week interim, lawyer Larry Williams, who had been retained by the Tobacco Institute, lobbied council members and submitted to them a 16-page legal brief on what he considered the constitutional pitfalls if the bill came into force.

'We must let facts speak for themselves'

Smoking risks--precise definitions needed

By Dorothy Trainor

MONTREAL — A McGill University professor of epidemiology finds statements concerning smoking and health less exact than they should be. She would like to see more precise research data in order to promote anti-smoking attitudes.

Scientists should continue to promote the development and dissemination of anti-smoking knowledge but do so "hand in hand with others who will ensure the distribution of knowledge as it exists — stating what is known and what is surmised clearly and without exaggeration," Margaret Becklake told the annual meeting of the Canadian Thoracic Society and Canadian Lung Association.

While emphasizing the importance of helping people to quit smoking, she said that a panel at the American Thoracic Society meeting in Boston this year faced the reality of how little impact anti-smoking campaigns have had.

Risks defined

"Reasons suggested were our tendency to dramatize for effect rather than allow the facts to speak, the exaggeration of effects which may not be biologically important, and our lack of specific information on the 600 or so chemicals in tobacco smoke," Dr Becklake said.

"Close to 50% of Canadian men smoke, but even amongst smokers, only one in 100 dies of lung cancer. What protects the other 99?

"For every 100 smokers, perhaps five will suffer heart attacks and die but the number for non-smokers is 3.5 per 100. Many women who smoke have perfectly healthy babies.

"Man needs to have his risks more precisely defined," she stressed.

The obvious 1980 target for "search and research" on smoking, she suggested, should be this individual susceptibility which she termed an "extraordinary selectivity in whom is affected by tobacco."

Power of information

"How much greater would be the power of information if it were more precise — if we knew exactly the elements in the complex aerosol of cigarette smoke relevant to the bronchial tree in the production of cancer, to the lung's parenchyma in the production of emphysema, to the walls of the blood vessels in the production of atheroma, and leading to myocardial infarction as well as peripheral gangrene where, incidentally, carbon monoxide is also suspected. Or, if we knew exactly the elements which evoked pneumonia in the children of smoking mothers," she said.

Dr Becklake, however, found some evidence cigarette consumption is falling. The number of regular male smokers had declined to 48% of the population in 1974 from 58% in 1965. The number of women smokers declined to 32% from 33% in the same period.

Statistics depressing

"But the fall is small. Many older people continue the habit and many young people take it up. More depressing is the high percentage of young Canadians between ages 15 and 19 who "smoke regularly — 32% of the boys and 28% of the girls according to a 1974 survey."

More interdisciplinary research is needed, she suggested, and the collaboration of citizens from all walks of life.

Early results in on acupuncture trials

By Lachlan MacQuarrie

HONG KONG — The out-patient treatment of addicts by acupuncture and electro-stimulation (AES) which was introduced in Hong Kong just a year ago, has achieved significant results in treating dependence on heroin and opium. This was revealed by the principal investigator of the AES pilot scheme, H. L. Wen.

This AES pilot study (**The Journal**, Nov, 1977) has been funded partly by the United States National Institute on Drug Abuse (NIDA), and partly by the Hong Kong Government. It involved setting up the world's first out-patient AES centre.

The specific aims of the study have been to examine the effectiveness of AES on a voluntary out-patient basis in detoxification, and to determine whether AES combined with supportive services can contribute to social rehabilitation of narcotics dependents.

"During the first year of operation", stated Dr Wen, "15% of the 300 drug addicts who volunteered to undergo the pilot scheme were successfully detoxified. This is a very high rate, if not the highest, of detoxification on an out-patient basis throughout the world".

Dr Wen is at present preparing a full assessment report for submission to NIDA. He will also be submitting a report to the central Hong Kong authority on drug treatment, rehabilitation, and control, the Action Committee Against Narcotics (ACAN), for consideration of whether AES should be permanently established as one mode of treatment in Hong Kong.

In the meantime, ACAN has endorsed a proposal to continue the pilot scheme, which expired on July 1, for a further six months pending a decision on its future establishment.

"The major advantages of AES out-patient treatment," said Dr Wen, "are that it is relatively inexpensive and does not require any kind of medicine. Addicts undergoing this treatment do not have their daily work affected as the treatment each day takes only 30 minutes."

In addition, said Dr Wen, "the period of treatment is relatively short — only 14 days. Moreover, drug dependents with a short history of addiction, particularly opium smokers, may require an even shorter period."

Since its establishment in July, 1977, at the Tung Wah Hospital here, the AES Centre has registered more than 900 patients, including the 300 who took part in the pilot study. More than 800 patients have been treated. The centre is equipped with 18 sets of AES machines and has the capacity to treat more than 30 patients at a time.

Dr Wen estimates the cost of treating each patient at the centre is at present about HK $51 (CAN $12) but is confident it will become even lower if the program is developed fully.

Australian pushers could get life

SYDNEY — Australia is introducing life imprisonment as the maximum penalty for importing large quantities of illicit drugs, and for second and subsequent offences involving any traffickable quantity.

The stiffer penalties will be introduced by the amendment of the Customs Act which, at present, provides for a maximum penalty of $100,000 and/or 25 years in jail, plus forfeiture of seizures.

The change is a response to the growth of professional criminal involvement and extraordinarily large quantities of narcotics and other dangerous drugs, with enormous potential market values, which are being detected.

Three recent cases involved 1,900 kg of cannabis resin, 10.8 kg of heroin, and 4.68 tons of buddha sticks.

Compulsory treatment is being considered as an alternative to other punishment for drug dependent people. This concept, however, is limited by the present capacity of treatment and rehabilitation facilities.

The situation is being studied by a National Standing Control Committee on Drugs of Dependence.

Thailand and US crack down on Golden Triangle

BANGKOK — Thailand is drawing up an extradition treaty concerning narcotics offenders with the United States.

Thailand's Secretary-General of the Anti-Narcotics Board, Maj-Gen Pao Sarasin said that although the country had extradition treaties with the US as well as British Commonwealth countries, narcotics offenders were not included.

He said many foreigners accused of drug charges had jumped bail and fled the country in the past, escaping prosecution. Revision of extradition treaties with foreign countries became necessary since most of the treaties were outdated.

Maj-Gen Pao also said Thailand's efforts to reduce opium production on the Thai side of the Golden Triangle by a crop substitution program is the right solution.

"And in order to encourage the hilltribe people to settle down in one place instead of destroying forests to grow opium, the Thai government has granted citizenship to some hilltribes who were born in Thai border areas."



Thailand's Committee on Public Education is in the midst of a public education campaign against drug abuse. Poster (above) warning about the devastation of heroin addiction, appears on billboards in Bangkok, in other sections of the country, and in educational pamphlets.

Hearts get new look in Finn 5-yr plan

By James Magee

GENEVA — The rate of heart disease in the North Karelia region of eastern Finland, is among the highest in the world, and about twice the average for Scandinavia as a whole.

But a remarkable campaign designed to bring about a change in lifestyle, with smoking as a major target, has given a new look to the statistics.

The results of the five-year evaluation are highly impressive in regard to the overall progress achieved. Cases of stroke, a disabling disease that can spell years of hospital treatment, have fallen sharply from 3.6 per 1,000 males in 1972 to 1.9 in 1975. The rate among women declined from 2.8 to 1.8.

Both the overall death rate in the population and the death rate from heart attacks, have fallen in both sexes, compared with figures before the project was launched.

Interestingly, the annual incidence of heart attack, or to be more precise, acute myocardial infarction, has hardly altered among men of middle age (taken as from 30 to 64 years). The rate has moved from 13.8 per 1,000 in 1972 to 13.9 in 1975.

But when the figures are studied in depth, it becomes clear there has been a big shift in the degree of severity of cases. "We have been getting far fewer really serious cases, which is a major reorientation," says one Finnish expert, Dr Hakan Hellberg of Finland's National Board of Health.

Women have by tradition been widowed early in this part of the world. Medical studies have shown that one male in two under 65 has suffered some kind of heart attack. The fear of the invisible killer is such that many people began to migrate from the area.

But, in 1972, Finnish health officials, working in collaboration with the World Health Organization, set up what they called the North Karelia Project.

After five years of operation, the first results from the project are attracting the attention of health authorities all over the world.

"What was involved was not only a battle against heart disease and the concomitant problem of stroke, but an attempt to change human behavior and lifestyle, leading to better health for all concerned," Zbynek Pisa, head of the cardiovascular diseases unit of WHO, said in an interview.

Director of the project in Finland is Pekka Puska of the University of Kuopio. He and his collaborators drew up a plan designed to zero in on what they consider the major risk factors for heart disease. In addition to smoking, they chose as targets serum cholesterol and hypertension.

Explaining how the campaign was put into practice, Dr Pisa said information about smoking, for example, and its attendant health risks, was brought to the public by every available means.

"Those involved in the project faced a major information problem. To reach as many people as possible in the community, they made use not only of the mass media, including television, radio, and the press, but also got the collaboration of professional health staff, including physicians and nurses.

"In addition, there was strong support by community groups. Trade unions distributed information material to their members, for example. Another source of support came from women's clubs and associations," Dr Pisa noted.

As a direct result, smoking habits changed. Most men in the region tend to smoke regularly and heavily. But the five-year check showed that the percentage of smokers among middle-aged men had fallen from 54% to 43%.

Similar success was registered in convincing more men and women to get treatment for hypertension, considered by most medical experts as a condition that leads frequently to heart disease and stroke. There were also effective campaigns for a change of diet, from high to low fat.

Dr Pisa also drew attention to the importance of the project in the context of preventive health.

"This is an exercise in teaching people to develop healthy living habits, and to give up unhealthy ones. Very little money was spent on the operation, which relied more on recruiting the support and participation of a community."

He pointed out that smoking, for example, is linked not only with heart disease but with respiratory disease, including emphysema and bronchitis, and also with cancer of the lung.



The county of North Karelia in eastern Finland is the target of a World Health Organization assisted health education campaign including anti-smoking education and reduction of high blood pressure.



Dr Pekka Puska (standing, above) principal investigator, coordinating centre of the North Karelia project, gives an educational course on the activities of the project to some 50 auxiliary nurses coming from health centres in all parts of North Karelia.

Exec alcohol centre to open

VICTORIA, BC — An new alcoholism treatment centre for executives and professionals will soon open on Vancouver Island.

Gillain Manor Ltd, located on Mount Newton, 15 miles north of Victoria, is scheduled to open its doors Oct 3. It will accommodate up to 100 patients at one time at a cost of $175 per day.

J. George Strachan, executive director of the privately run centre, said treatment emphasis will be on rebuilding the personalities and physical, emotional, social, and spiritual strengths of the patients, as well as their relationships with those close to them. Spouses and other family members will be included in the program.

Dr Strachan said he'd estimate an average stay of approximately 28 days, or an average bill of $4,900. He said Gillain now has 22 specialists in alcoholism treatment on its staff, and the number is expected to reach 45 to 50 by the end of the year.

William H. Rogers, president of Abacus Cities Ltd — the parent company of Gillain Manor — said: "We're looking specifically at the professional and executive levels, and in this group the effects of alcoholism constitute a tragic loss to their families and the community."

He said Abacus wanted to see Gillain become the Mayo Clinic of alcoholism treatment, but any profits derived from the project would be put back into alcoholism and drug dependency research to be controlled by the Gillain Foundation.

ARF launches School for Addiction Studies

TORONTO — The Addiction Research Foundation of Ontario is making a major effort to improve the training of workers in the alcoholism and drug field.

In mid-October, the foundation's new School for Addiction Studies will offer its first course.

Donald Meeks, director of the school, told **The Journal** it represents "a substantial new program thrust for the foundation" and the general intent is to coordinate the foundation's training resources "to deal primarily with the knowledge and management of addictions."



Donald Meeks

One of the shortcomings of the foundation in the past has been a lack of coordination of training facilities, said Dr Meeks.

"There's been a lot of good activity in the training area in the foundation over the years. But very often the same kinds of subject matter or programs aimed at the same target groups were planned in isolation. The quality has been uneven; and that's one of the things we'd like to correct with the school."

As an ARF-sponsored operation, the school will give top priority to ARF professionals and other staff seeking more education in the training area. Training opportunities will also be offered to other workers in Ontario. In addition, Dr Meeks said, the school will be performing functions within the foundation's role as a World Health Organization collaborating centre.

"The collaborating centre role is concerned with research and training, it focuses primarily on helping people in developing countries to improve the quality of their research, knowledge, and skills. The school will be a primary focal point for coordinating the training activities with people in developing countries."

The curriculum for the school has been divided into three major areas — fundamental concepts, specialized knowledge, and specialized skills training. Fundamental concepts will cover information that's important to people working in health and health related areas concerned with the alcohol/drug field.

"We're talking about things like pharmacology, social policy prevention strategies, and the status of research in the treatment area," said Dr Meeks. "We're talking about a range of information that would form a baseline of knowledge for anybody no matter what their vocation, or discipline, or function."

Specialized knowledge will involve study of particular issue or practice areas by people who need that kind of information. Such courses could cover topics such as assessment, training primary care workers, addictions among teenagers and the elderly, and marital and family therapy. Specialized skills training will often be coordinated with specialized knowledge programs and will provide training for people to perform particular functions.

At this stage, Dr Meeks said, the school is going to the ARF staff to get feedback on what is needed in terms of course content. "We're trying to go to the potential recipients to get information about what they need. As we move towards a wider audience we'll do the same thing with other workers and professionals in Ontario and with people from developing countries."

Dr Meeks stressed that the school "would not get into the business of indoctrination" or of trying to push a particular approach to addictions or treatment.

"The posture of the school will reflect the general posture of the foundation," he said. "There is a variety of beliefs, orientations, and schools of thought in the alcohol/drug field, and its important for people to have some appreciation of the range of explanations, possible techniques, and modalities. The school will be broad in its orientation."

At this stage, Dr Meeks said it would be premature to estimate the number of students who will be enrolled in the school. But the five-day "fundamental concepts course" will be presented four times a year with about 30 students per course. As many as 15 specialized knowledge courses could be offered with an enrollment of up to 30 students each.

In the first year, Dr Meeks expects most courses will be offered in Toronto "mainly for developmental monitoring and planning purposes." In subsequent years, different programs could be offered in various parts of Ontario, and programs elsewhere, such as in developing countries, could be supported.

The "faculty" for the school will be drawn mainly from the Addiction Research Foundation. "We see the school as really being the foundation's school," said Dr Meeks. "We see people in the research division, the clinical institute, regional programs, and the educational resources division as all being potential faculty people. We'll also look to the community if we feel the kind of expertise is there that we need.

"The school will be an integral part of the foundation's operation," he added. "We hope the staff see us as being there to meet their needs, but at the same time see themselves as contributors to planning and to the actual teaching, and not just as recipients."

Overseas workers focus of abuse aid

ZURICH — An international organization has been formed to assist corporations with overseas employees who are experiencing personal problems, including alcohol and drug abuse.

Ex-patriate employees, employees native to the country in which the company is operating, and third country nationals, or workers brought from a third country, are the focus.

One of the International Occupational Program Association's immediate goals is to assemble and distribute a directory of facilities in Europe and the Middle East available to help deal with troubled employees, according to Dale Masi of Boston College, Chestnut Hill, Massachusetts, and executive vice-president of IOPA.

Dr Masi says the organization also plans to document customs and laws of foreign countries with regard to alcohol, drugs, and mental illness; to assist corporations in establishing overseas occupational programs, and to help develop guidelines, policies, and strategies; to develop a bank of staff for such programs; and to initiate development of treatment facilities.

According to D. F. Lindley, one of the founders of IOPA, the number of overseas employees is constantly increasing as are the "obvious cultural clashes which, in many cases, accelerate the consequences of alcoholism."

He says the cost of replacing a worker can be as high as $50,000 to $100,000.

Mr Lindley, director of the corporate alcoholism program of Charter Medical Corporation in Macon, Georgia, says one aim of IOPA is to encourage the development of an international treatment centre. Among other things, it "would or should have screening and evaluation of those individuals for whom such assignments (overseas) would be counter-indicated."

IOPA is a "not-for-profit organization" and works with a United States government advisory committee whose members include representatives of the National Institute of Mental Health, the National Institute on Alcohol Abuse and Alcoholism, the National Institute on Drug Abuse, the department of defense, and the state department. It is based at 4 Mohawk Drive, Framingham, MA, 01701, USA.

British industries tackling drinking in the workplace

LONDON—British industrialists — after frequent warnings about the cost of excessive drinking and alcoholism — can now obtain a complex "resource pack" giving hints on how to tackle the problem in the workplace.

It has been produced by the Alcohol Education Centre (The Maudsley Hospital, 99, Denmark Hill London SE5 8AZ) and the Scottish Health Education Unit.

The pack has been welcomed by the Wine and Spirit Association here in a new publication *Drinking and Alcohol Problems* which says: "Whatever the approach one uses . . . there can be no doubt that for this whole question to be brought into the open is in itself an excellent and constructive step. As long as alcohol problems are swept under the carpet and ignored, it is likely that they will go on increasing. Only when the issue is confronted openly and debated sanely can we expect that significant advances will be made in the prevention and treatment of alcohol problems in employment."

The booklet says that if a company's alcoholism policy is to be effective, its terms must be clearly stated and must be known to all employees. Full consultation with trades unions and other interested parties "should occur from the outset."

Kit sold out

TORONTO — People wanting the resource kit on women and addictions, prepared by a group of Ontario women (The Journal, July) are going to have to wait, says Jessica Hill of the Toronto regional office of the Non-Medical Use of Drugs Directorate.

She told The Journal **only 200 copies of the kit,** *Women and Addictions: Alcohol and Minor Tranquillizers*, **were produced and the supply has run out. Meanwhile, Non-Mudd has been reorganized under the Health Services and Promotion Branch of the department of national health and welfare (See story page 1) leaving further production of the resource kit in question for the present.**

Copies that have been distributed are being shared, she said.

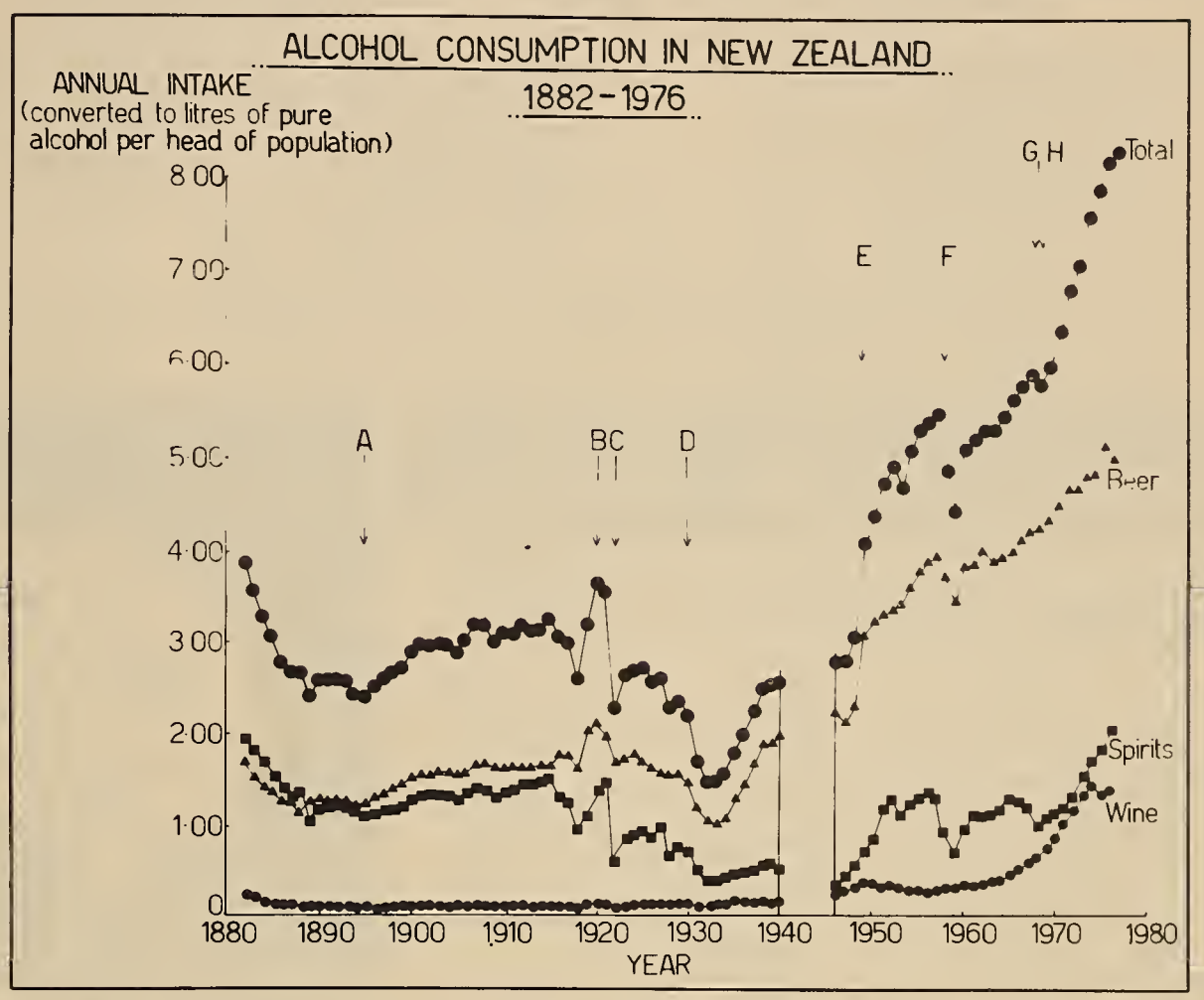
So they say:

We must be particularly wary of glib, seemingly facile, and seductive approaches and slogans. For, as that Baltimore sage, H. L. Mencken, has said: 'For every complex social problem, there is a solution that is simple, feasible, and wrong.' **Dr Ernest Noble, United States National Institute on Alcohol Abuse and Alcoholism.**

If you ask the question 'where' does the nurse become involved in prevention, intervention, referral, and counselling (of chemically dependent people) the answer has to be — wherever the nurse is. **Connie McClure, RN, Milwaukee, Wisconsin.**

To determine why Norway has such tight control measures first an answer would have to be given to the question whether it is the Norwegian alcohol policy that has caused alcohol consumption in Norway to be lower than anywhere else in the Europe — except Iceland — or whether it is the low alcohol consumption that has played a part in shaping Norwegian alcohol policy. **Ragnar Hauge, director, National Institute for Alcohol Research, Oslo.**

NZ's rapid alcohol rise



With 95 years of alcohol consumption figures available, New Zealand researchers have illustrated the fluctuations (above) and suggested some possible economic and social causes for them.

Says Professor R. D. Batt, department of biochemistry, Massey University, Palmerston North: "Clearly, recessions and taxes on alcoholic liquor have affected per capita consumption."

This is true, he says, except for the "present situation, with our high level of unemployment and an economic recession showing no significant signs of influencing the very rapid current rise in per capita consumption."

The possible causes, below, are numbered to correspond with an arrow and letter on the graph:

A The end of a long depression which had lasted some 20 years, dates from about 1895 after a banking crisis in 1894-95. From 1882 to 1895, beer and spirits were consumed in equivalent amounts, with respect to pure alcohol intake and there was a steady fall in total consumption per head of population.

From 1895, for 20 years through to the beginning of the First World War, there was growing prosperity and this was reflected in the rising mean levels of alcohol consumption.

B & C After the First World War there was a short post-war boom which burst in 1921-1922. These events are reflected in a rapid rise in per capita alcohol consumption and a dramatic fall to a minimum value in 1922. Consumption levels did not rise again to pre-war levels during the 1920s and the next major fluctuation showed in the consumption figures for 1931.

D The Wall Street crash occurred on October 24th, 1929 and, following it, exports from New Zealand fell by 40% in two years. Alcohol consumption fell to the lowest value in the whole period from 1882-1976, a per head consumption of 1.43 litres of pure alcohol per annum. Consumption began to rise again by 1934 and continued to increase until 1940, the last year in which consumption data were available until after the Second World War.

E On the 11th May, 1941, beer strength was reduced by ¼ and this was restored again by the beginning of 1949. The sudden rise in alcohol intake from 1948 to 1949 is presumably due to beer consumption being maintained, but, in 1949, with a considerably higher alcohol content.

F The so-called "Black Budget" of the Labour Government was introduced on June 26th, 1958 with increased taxes on both beer and spirits. The effect of these price increases were immediate with reduced per head consumption in 1958 figures and showing as a maximum effect for 1959.

G Another tax on alcoholic liquor was included in the budget presented by R. D. Muldoon on May 4th, 1967 but, in this case, it was confined to spirits. The per head consumption graph for beer showed no reduction whereas the spirits intake was markedly affected.

H On October 9th, 1967, 10 o'clock closing was introduced and ended fifty years of closing at 6 pm. The earlier closing time had been introduced in 1917 as a war measure.

Following the introduction of 10 o'clock closing, alcohol consumption per head of population has shown the largest sustained increase since official records have been available in the Yearbooks. The most marked rises have been in spirits and wine consumption which have more than compensated for a lessening in the increase in rates for beer consumption.

Although the 1976 total figures have not maintained the percentage increases of the previous six years, the per capita consumption is still increasing in a period of economic difficulties for the country.

A major contributing factor to the recent rapid rises in consumption may well be due to the introduction of evening entertainment in hotels. Traditionally, dancing and other forms of entertainment such as housie were not associated with alcohol consumption. In fact, strict laws were applied to ban the availability of alcoholic liquor at public dances. Now, a reverse situation applies, with dancing normally associated with drinking on licensed premises.

Such changes could account for the rising incidence of alcohol problems among the younger age groups in New Zealand.

Figures on alcohol consumption per head of population have been available in the New Zealand Official Yearbook since it was first published in 1892. In the first volume, consumption figures were given for the previous 10 years in a form which has remained essentially the same until the present time, i.e. as gallons (or more recently litres) of beer, spirits and wine consumed annually per head of population. The quantities represent the amounts of alcoholic liquors manufactured in the country, or imported, less any quantities which had been exported.

For the years 1882 to 1934 inclusive, the figures were given for the whole population and for the population excluding Maoris. Without any exception, in either total amounts consumed, or for the individual categories of alcoholic liquor, the Maori population did not drink as much, per head of population, as the rest of the population.

The approximate percentage alcohol contents of the three groups of alcoholic liquors follow:

Beer	3.8% volume/volume
Wine	15.0% volume/volume
Spirits	40.0% volume/volume

Most of the beer consumed in New Zealand would have an alcohol content of about 3.6% v/v but a proportion (up to 10%) has a considerably higher strength, and by using a value of 3.8% some compensation is made for the intake of higher strength beers. Wine includes both table and fortified wines ranging from about 10% to 20% in alcohol content. Since they are consumed in about equal quantities, an average figure of 15% is appropriate in estimating pure alcohol intake from the wine liquors.

EDITOR
Anne MacLennan

STAFF WRITER/PRODUCTION EDITOR
Karin Pargas

CONTRIBUTING EDITORS
Harvey McConnell (Washington)
John Shaughnessy (Toronto)

SCIENCE EDITOR
Dr Ruth Segal

The Journal

Published by Addiction Research Foundation of Ontario
33 Russell St, Toronto, (416) 595-6053

CORRESPONDENTS
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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Letters to the Editor

Going Dutch on pot

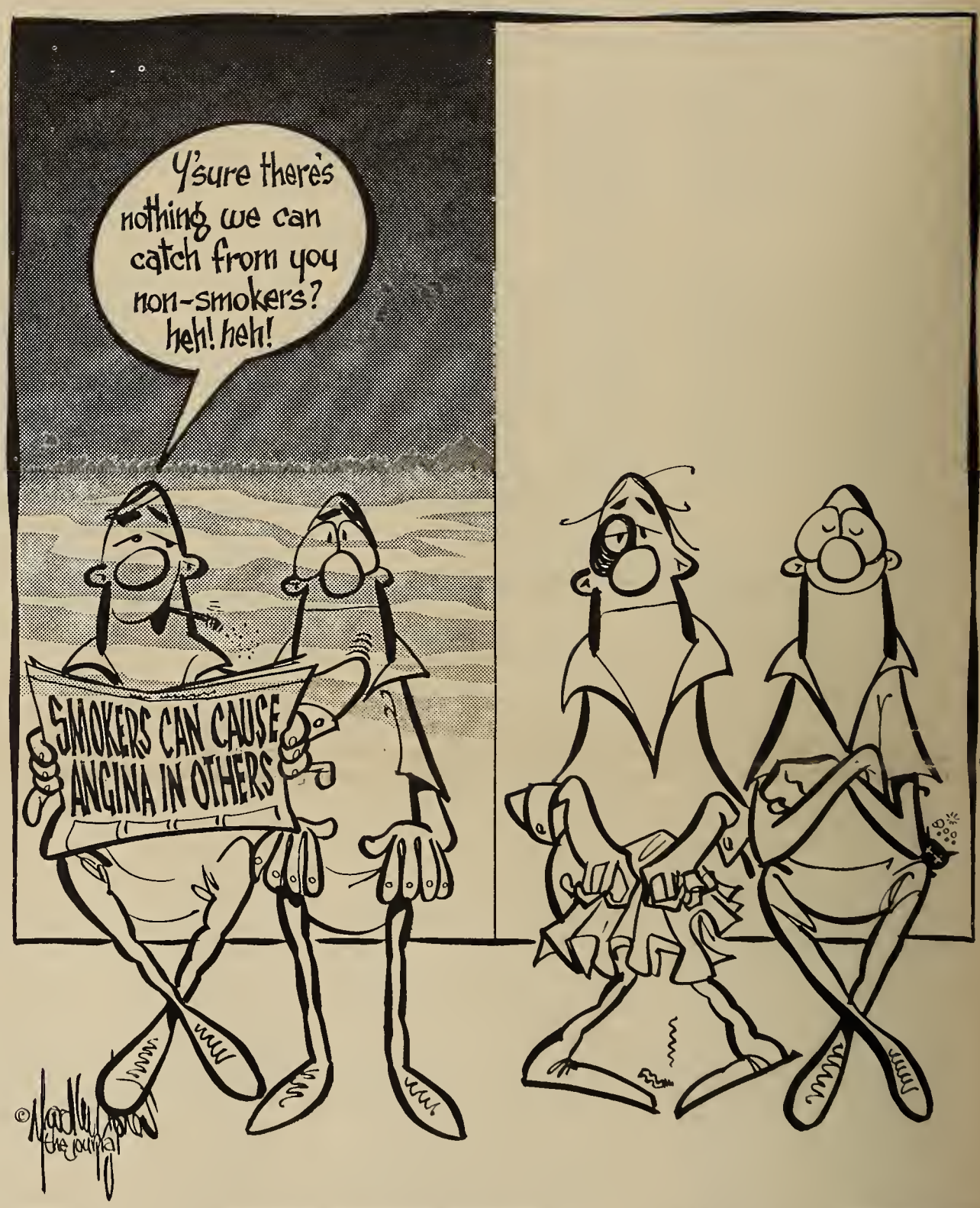
I read with pleasure in **The Journal** (June), that a Dutch government representative has informed an agency of the United Nations that his country would like to see the 1961 Single Convention on Narcotic Drugs altered as it applies to cannabis, letting each country decide for itself the extent to which it may be allowed for personal use.

What the brief article does not mention is how richly Dutch toleration anticipated this eventuality by permitting cannabis users their clubs.

In 1974, I was the salaried "house dealer" at *de Kosmos* in Amsterdam. In existence since 1970, with upwards of 200 visitors each night, it has a mixed sauna, macrobiotic restaurant, tea room, library, arts and crafts studio, classrooms for zen, yoga, and tai chi, as well as a large hall for music, dance, theatre, and films. I should point out that my responsibilities included directing clients to appropriate alternate techniques for entering the "high" state, and that strict limits governed their purchases of the drug.

In North America, experimentation on this scale would be quickly decommissioned by either a motorcycle gang or the local police. In Holland, it flourishes to give the Dutch at least one important option when they finally tackle the details of a complete normalization.

Emile Lefort
Toronto, Ontario



AA and 'true sobriety'

The letters by Pat Armstrong and Millicent Buxton on Alcoholics Anonymous (**The Journal**, April, June) are puzzling to me. They claim that AA is preoccupied with the past, and imply that the AA program does not deal with the present.

In several years of attendance at AA (and also Narcotics Anonymous) meetings, I've found that the emphasis was on living in the present effectively. While some speakers, at the first "speaker" meetings I've attended, seem to delight in their exciting (to some) "drunkalogues" I've found the participation, discussion, and study meetings almost always oriented to dealing with the problems of day-to-day living.

I continue, after almost 10 years of abstinence, to find AA extremely useful in keeping my thinking straight about daily living. When I find that a subject irritates me, it's usually because I need to work on a problem in the area I'm trying to ignore.

AA/NA is a stepping stone toward more growth-oriented activities, and if one looks for them they can be found in AA/NA. It's called "Working With Others" or "Twelfth Step Work." Not only does it help others to find sobriety, but it also strengthens the sobriety of the helper.

Continuing sobriety, as differentiated from "dryness", is my goal. Self-preoccupation, to me, is not sobriety, and being only dry leads to a dry drunk, which is not sobriety. Sobriety is a dynamic process of living a constructive life, one day at a time, building serenity and secure self-worth. I've tried many other methods, but only AA has worked for me, in the pursuit of this goal. Maybe AA isn't the only way, but it's the only one that has worked for me.

W.A.W.
La Puente, CA

Le Soleil continued...

I would like to congratulate Wayne Howell on his column The Ballad of Le Soleil (**The Journal**, June). Indeed, such heroic verse demands a reply in kind:

A work of art this ballad was,
The story of Le Soleil.
How fearless legal minds rushed in,
to scoop up the elusive prey.
Many kudos now should go,
to the teller of this tale.
As the facts were clear, the message
strong, and humor did prevail.
So Doctor Howell let me say,
your piece was just terrific.
We all enjoyed it much better than
some research scientific.

Richard Paton, PhD,
Ottawa, Ontario

Western AA also strong in Japan

David Milne's article, Alcohol keeps the country from exploding (**The Journal**, April), dealing with alcoholism and alcohol abuse in Japan, refers to the *Danshu-Kai* movement as "Japan's version of Alcoholics Anonymous with important differences. . . ."

The statement, I admit, is literally accurate, however, it can be grossly misleading since it implies that traditional AA as we know it here in the western world and in Europe has somehow failed to take hold in that Oriental land. Such is not the case!

Be advised that AA exists and AA groups have been meeting in Japan for at least two decades although with limited visibility. There has been a tremendous increase in the number of AA groups established in Japan, especially in and around Tokyo, during the last three years.

One final note, Japanese AA members tend to use the English term "higher power" rather than a translation because the concept is not easily expressed in the Japanese language.

Walter J. Flinegan
Special Assistant to the Director
State of New York
Division of Alcoholism and Alcohol Abuse
Albany, New York

'Cloudy' on second-hand smoke

I have been a loyal and supportive reader of **The Journal** since its inception and consider it one of my "read first" items among the plethora of written material I receive. I have been particularly pleased with the introduction of the "factsheet" supplements and focus on smoking in the recent past.

Given this well-deserved positive feedback, I wish to voice my strong disapproval at a statement included in the November "factsheet" on tobacco. Specifically, under the heading of 'Non-Smokers' Rights, the lead sentence is: *There is no evidence that a tobacco-smoke filled environment is bad for the health of healthy non-smokers, except possibly children.* With all of the recent research illustrating the *very* harmful effects of "second-hand smoke," I feel your remark is not only misleading but as such is a *non*-fact. As I have come to expect a high degree of accuracy in material reported in **The Journal**, this type of remark is one I would expect from some cloudy thinking — sort of what might occur in a "tobacco-smoke filled environment" . . .

Arnold L. Felner, ACSW
Veterans Administration Hospital
Miami, FA, 33125

'Excellence'

The Journal is excellent and much appreciated. Congratulations on honor from the World Health Organization referring to "excellence" (**The Journal**, Jan).

A. Spencer Paterson, MD
London, England

'Client rights' - part of a larger set of concerns

Can human dignity survive bureaucracy?

By M. Ellen Moffett, MA

Client rights have become of more and more concern to the field of drug abuse and, specifically, to the therapeutic community within the last year. By client rights, I mean issues arising from society's neglect or abuse of a given individual, or population, as a result of that society's dependence on highly centralized and bureaucratically organized agencies to deal with "social problems."

To understand the nature of the client rights question, it is imperative to see "client rights" as one part of a larger set of concerns created by the development of economically advanced, highly industrialized societies.

Sheer neglect

A major consequence of industrialization has been to transform citizens into clients. That is, populations in industrialized societies are increasingly dependent on the services and decisions of large, impersonal, bureaucratically organized agencies. This has appeared in two major forms.

A large number of social problems ranging from crime and delinquency to madness, poverty, and the care of the aged poor, and which in medieval times were handled by the family, church, and community, have passed into the jurisdiction of the prison, the juvenile detention centre, the poorhouse, insane asylums, and old age homes. Problems which were previously handled locally, informally, and personally, within the family or community, have become matters of public responsibility. In addition, almost all social activities, including education, production, and politics, have shifted out of the family and local community setting into massive bureaucratic hierarchies.

This revolutionary transformation of social life has created several novel potentials for abuse. One is the sheer neglect or brutalization of that growing portion of the population confined to institutions, a source of repeated scandals usually rooted in the chronic underfinancing of public institutions. Another is those forms of abuse that stem from the dependency of citizens on highly centralized organizations over which one has little control and within which one is frequently a mere cog subject to distantly formulated decisions, motives, procedures, authority, and rules.

Dehumanization

Violations of rights appear as problems of abusive working conditions and work safety, exposure to hazardous materials, police abuse, and abuse of political power. In addition, a larger group of abuses arises out of the invasion of privacy or violations of one's civil rights brought about by the increasing power, resources, and technical sophistication of large modern agencies.

One of the most dangerous kinds of abuse peculiar to a centralized and bureaucratically organized social order arises from the fact that the rights and welfare of those affected are frequently not taken into account in the decision-making process. Although it is often unintentional, decisions are made oriented to increasing profits, or economy, or efficiency, or for reasons of national security, which result in the serious violation of individuals' rights and welfare.

These abuses frequently appear or come to public attention as legal issues in the guise of violations of civil or clients rights. Examples are the involuntary incarceration of the aged poor in mental institutions, police brutality, and sophisticated invasions of privacy. However, although in such cases legal rights are indeed violated, these violations are only a small part of much more serious questions:

- *How should society provide for that large population requiring confinement, care, retraining, medical or psychological assistance — needs which have become collective and public in nature?*
- *How can individual dignity be preserved in an increasingly bureaucratized society with its vast potential for dehumanization? How is society to prevent the subversion of the ends or ostensible purposes of organizations, to prevent the means from becoming ends in themselves?*

These are serious social questions engendered by the distinctive organization of modern society. They normally come to our attention as violations of civil rights because of the failure to deal adequately with the social question. That is, they appear as violations of client rights as a result of the failure by society to provide responsibly for the social need.

The insistence on rights, while forgetting the larger social questions which subsume them, can have horrendous consequences. Take, for example, the aged poor involuntarily warehoused in mental institutions. The real question is: What is society's obligation to provide for this population? The legislators choose not to ask this question, but to treat it as a civil rights issue. As a result, the aged poor were delivered out of the asylums into the hands of unscrupulous nursing home operators. The rights issue, which demanded that the aged be *released* from involuntary incarceration, avoided the more serious moral issue of society's unwillingness to provide adequately for a dependent population. The aged condition was not improved at all, it merely changed form. In effect, it decreased the expenses incurred by the State in caring for this population, while shifting the scandal inherent in the situation from the public mental institution to the private nursing home.

Patterns of abuse

It is in this context of an attempt to deal with a basic social need, that the issue of client rights in the Therapeutic Community form of treatment arises. The TC developed as an effort to deal responsibly with the special problems posed by a population unable to function in society — the habitual criminal, the drug addict, and the alcoholic. The strength and success of the TC lies in the fact that it does not isolate the outward manifestation, such as drug abuse, from the whole individual. Patterns of drug abuse, alcoholism, or criminal behavior, frequently reflect a larger failure of the individual's ability to function in society. The abuse is typically associated with a larger syndrome of acquired attitudes towards self and others — authority and values which place the individual consistently in conflict with approved social behavior and roles, at incalculable cost for both the individual and society. These are people for whom the initial "socialization" process, which all society's members undergo, failed.

Self-contained world

The TC is, in effect, an adult socialization program, a second chance in a highly condensed form, to achieve that which failed the first time.

The problem shared by most clients in the TC is that they have failed to achieve, or have rebelled against, the ordinary accommodations necessary to function in the world — good work habits and respect for authority, self-discipline, the ability to tolerate the frustrations of daily living, and acceptance of responsibility.

The TC program works by isolating clients from their dysfunctional external environment, the environment which sustains and nourishes their maladaptive patterns of behavior, and plunges them into a self-contained world organized systematically to inculcate habits, to instill through practice, and to teach and reward the behaviors and values necessary to succeed in the outside world. These include taking part in necessary work activities, learning to cope with others, exercising self control, accepting responsibility, and dealing with frustration and anger or hostility in fruitful ways. In the course of the program, just as in the outside world, destructive behavior is punished, and progress in learning and practising socially affirmative traits is rewarded. Punishment for breaking rules, for failing in duty or responsibility, takes the form of ostracizing the individual and confronting him on the issues. The confrontation is intended to bring out into the open, and to debate and argue, the reasons for the rule or duty, and the consequences should no one follow it.

Complete immersion

On the opposite side, progress in developing functional habits and attitudes in showing responsibility, ability to cope, getting things done, and working with others, is rewarded, very publicly, by grant of privilege, by promotion to positions of responsibility, by allowing greater freedom of movement, and by according esteem. In this way, the TC tries to duplicate the outside world in microcosm, with its system of work and authority, hierarchy and rules, privilege and punishment, reward and promotion. The person who succeeds re-enters the world fully equipped.

The aim of the TC is not to create robots. On the contrary, one strength of the TC which is often lacking in outside society, is that through constant encounter, open expression, and argument, the rules of society are discussed and critically examined. The question "Why are there such rules?" is openly and uncompromisingly examined.

The result is not to hammer in blind obedience: on the contrary, it is precisely by subjecting rules to attack, by asking why is the rule necessary, or why couldn't we get along without it, that clients discover for themselves the necessity of rules, and learn that an organized society of individuals requires rules if it is going to function. So rules are accepted not as arbitrary "musts," as resignations to externally imposed necessities, often a source of the initial rebellion, but as rational, conscious, critical, clearheaded, reasonable accommodations and restraints necessary to the functioning of any society.

It is imporant to understand that certain conditions are essential if the program is to work. Since the client's pathogenic behavior is part of a larger system of dysfunctional values and behaviors, reinforced by his chosen environment and friends, neighborhood, role models, etc., the individual must be isolated from this external environment, and immersed completely in the insular, comprehensive microcosmic society of the TC. If, while the individual is in treatment, he is free to come and go as he pleases, entertain friends and relatives, send and receive mail and phone calls, tend to his possessions, pursue business ventures, or marry and support a family, the external environment which landed him in the TC in the first place will remain his primary and abiding orientation. The links will not be suspended, no fresh start will be possible, and the program will, of necessity, fail.

Also, the TC treatment program is a self-contained world, with its own hierarchy, levels of responsibility and authority, and system of privileges, distributed strictly according to progress in the program and reflecting earned status. It is essential that all differentiation among clients in the program directly reflect client standing and progress in the program. If clients are able to create their own world of material possessions within the TC, according to their means, to transform their space into apartments decorated with stereos, record collections, televisions, cameras, and refrigerators, if poor clients are dependent upon the House, while clients with more substantial resources are free to stock their rooms with cigarettes, candy, food, and magazines, morale will be shattered, and black markets, bribery, and extortion practices will preempt the authority structure of the TC just as has happened in many prisons. Strains, jealousies, and frustrations wholly extraneous to the program will come to dominate interaction among clients. The program will become a shambles, the TC will be reduced to a prison, a detention centre, struggling to contain rather than to change the behavioral patterns and attitudes it receives.

Many TC clients have only two options open to them. They are people chronically unable to adapt to life's demands or circumstances. Many of them, without help, will drift in and out of trouble their entire lives, and be burdens to themselves and society. The alternative is nothing less than a prolonged program of resocialization, of learning. Where people agree to undertaking this program, they accept beforehand that they will be subject to suffering a long and demanding learning process involving rigorous sacrifices. They know that socially they will, in effect, become children again, and that they will be openly regarded as such. They also know that as with children, certain rights normally enjoyed by adults will be suspended and then rewarded to them slowly over time as tangible marks of their progress toward re-entering society. All of this is accepted by those who stay with the program: it's an indispensible condition of succeeding in the decision to escape their self destructive past and the future that surely waits.

Thus, rights are not being trammeled out of neglect, brutality, expediency, but voluntarily suspended for a period in order that they may be regained under new conditions where they can be genuinely enjoyed.

The question, at heart, is: what responsibility does society have to these individuals? Should they be able to enter such a program as they desire? If not or, if the program is to be rendered ineffectual, what options does society have to offer them? What is to be done for this population if the Therapeutic Community is destroyed?

Since rights violations are the result of a failure of society to provide for social responsibilities, the clients rights issue is not fundamentally a legal question but a social one — it should be a movement, a sentiment not to promulgate unworkable blanket legislation, but to press society to fulfill its human and moral obligations to safeguard and improve the rights, needs, and well-being of all of the population.

M. Ellen Moffett is the recently-appointed executive director of Gaudenzia, a state-wide human service organization in Philadelphia based on therapeutic community principles. She was formerly deputy executive director.



Alcohol a lubricant of violence, say NZ police

By Pat McCarthy

WELLINGTON, NZ — While breweries prepare to join forces in a marketing plan to promote beer as "the drink of moderation," the police have denounced alcohol as New Zealand's "lubricant of violence."

In hard-hitting submissions to a parliamentary select committee on violent offending, Commissioner of Police Robert J. Walton produced evidence linking increased consumption with an almost doubling of violent offences between 1967 (when hotel closing was extended from 6 pm to 10 pm) and 1976. And he called for measures to break the link.

He said the lowering of the legal drinking age from 21 to 20 in 1969 had an effect greater than commonly realized. The hotel scene changed also as pop groups and cabarets established bars as entertainment centres, replacing local dances as meeting places for young people.

Alcohol-inspired violence could be cured in the long term only by educating people to control themselves and to accept the responsibility that went with the freedom to drink, Mr Walton said. He urged smaller hotels, tighter controls over the granting of licences to hotel managers, and the replacement of glass beer jugs, bottles, and glasses — often used as weapons in bars and outside them — with plastic containers.

(Plastic jugs have already been introduced in many bars and plastic "glasses" are on trial, but the breweries say plastic bottles are not practical because they cannot stand the heat in the bottling process.)

Noting the disproportionate involvement of Maoris and Pacific Islanders in violent offending, Mr Walton said the way of life in New Zealand was totally foreign to people arriving from Pacific villages, and the hotel tended to become their culture centre.

Though liquor was nothing new to Cook Islanders, Samoans, and Tongans, in Samoa the cost of alcohol relative to wages tended to restrict consumption, and in Tonga a person required a permit to drink liquor.

Consumption of absolute alcohol is steadily rising in New Zealand. When the 1967 extension to 10 pm ended 50 years of 6 pm closing (and its notorious "six o'clock swill"), annual intake began its sharpest increase since records began in 1882.

Between 1968 and 1975, consumption of pure alcohol rose from 8.55 litres to 11.36 litres for every person aged 15 and older. According to Lewis Bieder, medical advisor to the Alcoholic Liquor Advisory Council, it will reach 20 litres by 1980 if the trend continues.

The rise in absolute alcohol consumption is partly because New Zealanders have since 1975 been drinking less beer and more wines and spirits.

The breweries' joint plan to promote their "drink of moderation" is a late response to a wine consumption that has tripled (per head of population) in the past 10 years and spirits sales that have risen by 60%.

"Beer gets most of the blame for social problems like drinking and driving, and street violence, but perhaps some of the criticism is ill-directed," says a brewery executive. "We think it is time beer started defending itself."

Whether the breweries succeed in giving their product a "moderation" image, they will not suffer financially from the change in New Zealanders' drinking habits. The three brewery groups also have large interests in most of the wholesale wine and spirits distributors.

Hazards of breath testing

AUCKLAND, NZ — Drinkers in New Zealand have turned bar room breath testing into a slot-machine game.

For this reason, the major breweries have decided against installing Canadian-designed breath testers in their hotels.

After inserting a 20 cent coin in the machine, the drinker uses a straw to blow a sample of breath into the analyzing system. The machine then gives a digital read-out of the blood alcohol level.

"We found that, instead of being used as a device to detect if someone is competent or not to drive, they have become a dangerous hotel game," said one brewery spokesman after an investigation of 20 machines already installed.

"Drinkers use them to have drinking contests — to see who can achieve the highest reading.

"If, for instance, someone is well over the 100 limit, but his mate has scored higher, he goes back to the bar for a few more drinks to catch up."

Heavy drinkers know alcohol levels

CHRISTCHURCH, NZ — People who have been drinking are poor judges of their blood alcohol levels — but heavy drinkers score best.

These results were obtained by a team from the department of clinical biochemistry at Christchurch Hospital when they set up a sampling station one Friday night in a central city area near several hotels.

Of the 161 passersby (33 female and 128 male) who volunteered to guess their blood alcohol level and then have it measured by gas chromotography, less than one third guessed within 20% of the true level.

Those with low levels had a marked tendency to overestimate (some who had drunk one or two glasses of beer or spirits thought their levels could be as high as 150mg per 100ml). Those with high levels tended to underestimate.

No age group guessed more accurately than any other. But 13 of the 16 who had levels above 200mg per 100ml guessed within 20% of the measured level.

"Clearly, these people were well aware of their state of intoxication," the authors reported in the *New Zealand Medical Journal*. "That they were capable of walking at all indicates a large and regular intake of alcohol."

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You should have a Master's degree or equivalent preferably in the Addictions Field with demonstrated competence in theory and practise of Drug Addictions etiology and interventions; demonstrated ability to plan, implement and obtain co-operation for training of senior professionals in Addictions Management.

Apply in writing to the:

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Addiction Research Foundation
33 Russell Street
Toronto, Ontario
M5S 2S1

Around the World

Pub crawl

Cancer research in Birmingham England's Queen Elizabeth's Hospital will continue — thanks to a sponsored pub crawl. A total of £2,000 was raised from the charity stunt. Twenty teams — each consisting of three drinkers and a non-drinking driver — toured 20 pubs in the area.

Scrip forgeries

Forgery of prescriptions in Northern Ireland has reached alarming proportions, according to the drugs squad. In no less than 43% of drug offences, forgery of prescriptions has been a feature. Doctors, say the squad, are either absent-minded or careless, leaving prescription pads on desks and in unattended cars. Theft is not detected, since only a few forms are removed at a time. It becomes easy for an addict to steal the forms and make out a prescription for pethidine, nembutal, tuinal, endrax, or amphetamine.

Alcohol taxes

A survey of tax rates among 15 nations which reported for 1970 indicates that Sweden ranks first, with a rate of $12.12 per litre of absolute alcohol. Italy is lowest on the scale with a rate of 60 cents. In descending order following Sweden, countries' tax rates are Norway ($11.41), Denmark ($7.80), Great Britain ($7.58), Finland ($7.33), Canada ($7.30), Australia ($5.15), United States ($4.97), Japan ($4.56), Czechoslovakia ($3.60), Netherlands ($2.86), German Federated Republic ($1.70), France (87 cents), and Austria (60 cents).

Smoke puffs

Hard smoking doctors at a London hospital spiked off a fire alarm. A group of them were relaxing in their library when clouds of dense tobacco fumes set off a smoke detector. Four fire trucks rushed to the scene only to find the doctors had diagnosed the problem and cured it by opening a window. A hospital spokesman said: "It just shows how sensitive our smoke detectors are."

Tackling vodka

Soviet government concern for drinking problems has taken many forms. In Siberia, police wagons wait outside taverns to pick up intoxicated patrons so they won't fall into a snowbank and freeze to death. Liquor taxes already represent 80% of the cost of alcoholic beverages in Russia, but the higher taxes haven't slowed down drinking. The average worker spends from 10% to 15% of his pay for vodka, about five times what the average American worker spends on drinks. State-operated sobering up stations now impose stiff fines and subject drunks to public lectures, and organizations similar to Alcoholics Anonymous, are springing up all over the USSR.

Tobacco giants

Multi-national tobacco companies, led by British American Tobacco are pushing the sale of high-tar cigarettes in Third World countries, according to a report by the War on Want charity. The allegations denounced by BAT as "wild" include charges that many cigarettes sold in Zambia, Kenya, Sri Lanka, and Malaysia contain much higher tar levels than would be acceptable in Britain. Also, packets in these countries don't carry health warnings. The report added the long-term plan of the tobacco companies is to get smokers in these countries hooked on high-tar locally-produced cigarettes and then switch to lower tar cigarettes made in the West — ensuring a captive market. BAT admitted it sold high tar brands in Third World countries, but said consumers could smoke lower-tar cigarettes if they wished.

Thai heroin

A Dutch woman has been sentenced to 30 years imprisonment in Bangkok after being found guilty of possessing and attempting to smuggle heroin out of Thailand recently. The woman was arrested by Thai customs officials before boarding a plane for Amsterdam.

Plan will affect even tourists , diplomats

India aiming for total abstinence



Morarji Desai

NEW DELHI — By 1982, India wants total prohibition on consumption of alcohol — by its people, its visitors, foreign workers, and even by people on aircraft flying into and out of the country.

Early components of the four-year plan are shown (right) in this clipping reproduced from the New Delhi publication — *Organiser*.

The plan of India's Prime Minister Morarji Desai, it follows the line advocated by Mahatma Gandhi.

Some restrictions are already in effect. Dry days in the capital have been increased to include Sundays, public holidays, and the first two days of each month. On dry days, Indians are not served liquor in any of Delhi's hotels — even if they are guests of foreigners, the qualification for being served on dry days.

Ultimately, it is expected the entire population will be affected. Even foreign embassies and consuls in the country will be required not to serve liquor to any guests.

There are two considerations which could be seen as both reasons for and obstacles to implementing the plan, according to some Indian workers in the alcohol field.

There has been a significant increase in alcohol abuse by young people in India. Experience in other countries of the world suggests it may not be easy even to curb, let alone stop this trend.

Also, India depends to some extent on tourist money and tourists are not renowned for their temperance. Will the tourists and foreign workers still come if alcohol isn't part of the itinerary?

TOTAL PROHIBITION WITHIN FOUR YEARS

—The Prime Minister promises

Drinking is evil
It destroys the family
It encourages crime
It discourages development of a healthy society

ADMINISTRATION WANTS TO FINISH THIS EVIL

By educating people
By removing the source of evil
Therefore Administration has planned to declare more dry days

- All Sundays and Wednesdays
- All gazzetted and restricted holidays
- The Martyrs' Day (January 30)
- And the first and seventh of each month

To stop public serving of drinks

- At club and hotel bars
- At official parties
- In public places

To restrict hotel bar service to foreign tourists only
To ban a foreigner offering a drink to an Indian at a hotel bar
To make dry days applicable to the tourist hotel bars also
To reduce the number of whisky shops from 32 to 28

- Country liquor shops from 12 to 10
- Wholesale licences from 19 to 14

To allow liquor shops only in commercial areas
To shift liquor shops on demand from citizens
Not to allow liquor shop in residential areas
To restrict shopping hours from 11 a.m. to 7 p.m.
To declare a five kilometer belt along the border dry
And double these measures in each ensuing year till the end of the fourth year when Delhi will be totally dry
Ban display boards and shop signs in neon lights
Prescribe the size of sign boards at shops
Make it compulsory for each liquor bottle to carry health warning

- In Hindi on country liquor bottles
- In English and Hindi on Indian made foreign liquor

Prominent display of health warning "Consumption of liquor is injurious to health" at the liquor shops

And educating peaple against the evil of drinking by:

- Displaying slogans on DTC buses
- Distributing publicity material
- Organising film shows, dramas and dances denouncing drinking
- Sponsoring public meetings and exhibition on nasha bandi
- Giving grant-in-aid to voluntary bodies propagating prohibition
- Strengthening de-addiction clinic service
- Naming and Excise department as Department of Excise & Prohibition

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Disulfiram 'turning point' for alcoholics: Davidson

WINNIPEG — Long-acting disulfiram implantation in 600 alcoholics caused 85% of them to give up drinking during a clinical trial here and the majority to later join rehabilitation programs.

The trial has proved so successful that disulfiram could become a major way to treat alcoholics, according to W. J. Davidson, trial director and conjoint and associate professor of psychiatry, pharmacology and therapeutics, and director of pharmacology at Winnipeg's Health Service Centre.

Dr Davidson told **The Journal** the Manitoba trial is the first one in the world where followup has been intensive. Previous trials in France, where the five dollar-a-patient drug is manufactured, produced only anecdotal follow-up results.

He feels the trial has been so impressive lobbying should begin to make disulfiram implantation available as an orthodox treatment under medicare.

In the trial, 10 small disulfiram tablets were placed under the abdominal skin in a simple operation using local anesthesia. The drug is released gradually over a 12 to 18 month period.

If the patient takes a drink — most challenged the drug between three and five months after implantation — he or she becomes violently ill for several days until two enzymes blocked by the drug can resume production and break down the alcohol.

Dr Davidson said once they got over the alcohol induced illness some 85% of the patients did not drink again while the drug remained active.

Some patients required a second implant to help them stay off alcohol, and fewer than 10% developed an immune reaction and had to have the implants removed.

A large majority of the patients have gone on to make major social and physical recoveries, even with less than ideal social service followup. These include regaining social stability, family unity, job status and an interest in physical fitness.

Reports of the trial's success have resulted in an avalanche of requests for treatment by alcoholics. Many have had to be turned down.

Dr Davidson says: "People who did have the implants and drank got sick enough to persuade them not to drink again. It was the kind of persuasion they needed, seeing that they already wanted to quit drink but couldn't, which is the case with about 19,500 out of the 20,000 alcoholics we have in the province.

"We don't want to see people needing implants for the rest of their lives, but maybe there are cases where this is the only thing that can be done.

"The implant is not God's gift to mankind. It is not a cure for alcoholism. But, with most people, it will buy 18 months of sobriety. During that time society — the Salvation Army, Alcoholics Anonymous, religious groups, hospitals, anything — has got to get to these people, and help them change their lifestyle so they no longer have this need to drink.

"And if the followup and rehabilitation service is there and stays on top of the case, the implants will have been the turning point in the lives of these alcoholics."

The present three year trial program has cost about $80,000 and the money was donated by the Manitoba Medical Service Foundation, the federal government's non-medical use of drugs directorate, the Alcoholism Foundation of Manitoba (financed by the province) and the Winnipeg Foundation.

Dr Davidson estimates direct treatment could come to around $100 a patient under the program.

Criminal court works hand-in-hand with agency

Alcohol program hits drug abuse

GREENVILLE, SC — A program modeled directly on a successful program for alcohol abusers has shown to be as effective for drug abusers after 18 months operation in South Carolina.

This has been particularly true in more metropolitan counties like Greenville, where until four years ago there were no real programs for either alcohol or drug abusers.

One of the major successes has been with the court system, and it was at the suggestion of the magistrates and judges that the present program for drug abusers came into being.

James Haynes, director of the Greenville County drug and alcohol abuse agency since its beginning, said relations with the courts "have been a very nice revelation for us. We have had such a success with the criminal justice system that it suprises us sometimes."

The alcohol safety action program (ASAP), which was tried out in selected areas around the country a few years ago, was shown to be so effective in South Carolina that it was adopted on a statewide basis.

The ASAP program involves assistance and counselling for those with alcohol problems, especially people arrested for drunken driving.

On the heels of this success, Mr Haynes said: "The judges actually sought us out and asked what could we do for drug abusers along the same lines." It was decided to apply the ASAP program to drug offenders, and it works.

Every day one of Mr Haynes' counsellors tours the county jail.

"If we find people whom we think we can help, then almost 100% of the time when we go before the court, no matter if the charge is drunk driving or small possession of drugs, we can get whomever we want, just about."

The exception are drunk drivers who are involved in a serious accident, or those arrested for dealing in drugs. "Nor will we touch anyone if they are not interested in help," Mr Haynes added.

The major requirement for those directed by the court into the program is six to eight group counselling sessions. Attendance is often a condition of parole.

Another important service the agency provides is helping youthful offenders erase their records.

"Under South Carolina law if you are under 21 you can have your record expunged if you complete the treatment program successfully. In most cases, we can have the court record erased," Mr Haynes said.

'Releases'

LONDON — The British welfare agency specializing in problems relating to drug use, Release, has published two new pamphlets, Drugs, a Basic Guide, which aims to inform people about legal and illegal drugs, and Drugs and the Law, which explains the Misuse of Drugs Act passed in 1971. They can be obtained for 20p and 10p respectively plus postage from Release, 1, Elgin Ave, London W.9. Tel: 01-289-1123.

ADDICTION RESEARCH FOUNDATION **NEW RELEASES**

AUDIO CASSETTE PRESENTATIONS

AT-013 CHANGING THE DRUG DEPENDENT LIFESTYLE

21 minutes *by Anne McKay*

Lifestyle change is a difficult challenge facing alcohol and drug abusers. Anne McKay, formerly an occupational therapist with the Addiction Research Foundation of Ontario, discusses leisure related problems, leisure counseling, and the basics of a leisure service. Program planners, counselors, occupational therapists, and recreationists should find this information useful, not only in assisting alcohol and drug abusers but also in developing preventative mental health, pre-retirement, community re-entry, and other lifestyle change programs.

AT-014 SOLVENT AND AEROSOL ABUSE

25 minutes *by Alec Gabe, Frederick Glaser, and Adrian Wilkinson*

What are solvents and aerosols? Who abuses them and why? What can the community do about it? These questions and others are explored in a wide-ranging discussion including Mr. Alec Gabe, information counselor; Dr. Frederick Glaser, head of psychiatry; and Dr. Adrian Wilkinson, clinical psychologist; all with the Addiction Research Foundation of Ontario. Approaches to the management and control are presented along with a discussion of the evaluative process.

AT-015 DRINKING-DRIVING COUNTERMEASURE PROGRAMS

24 minutes *by Pamela Ennis*

The focus in this presentation by Dr. Pamela Ennis, a scientist with the Addiction Research Foundation of Ontario, is on drinking-driving countermeasure programs Strategies of primary, secondary, and tertiary intervention are considered and their effectiveness is discussed in the context of general and specific deterrence

OTHER CURRENT TITLES

AT-001 **PREGNANCY AND DRUGS** *by Barbara Tucker*

AT-002 **FAMILY THERAPY** *by Reesa Kassirer*

AT-003 **WOMEN AND PSYCHOTROPIC DRUGS** *by Ruth Cooperstock*

AT-004 **COUNSELLING THE CHILDREN OF ALCOHOLICS** *by Kathleen Michael*

AT-005 **DETOX CENTRES — THE ALTERNATIVE** *by Dianne Hobbs*

AT-006 **COCAINE** *by Oriana J. Kalant*

AT-007 **CONTROLLED DRINKING CONTROVERSY** *by Norman Giesbrecht*

AT-008 **THE WOMAN AND HAZARDOUS DRINKING** *edited by Deborah Levine*

AT-009 **TEENAGE DRINKING: USE AND ABUSE OF ALCOHOL** *by Reginald G. Smart*

AT-010 **EMPLOYEE ASSISTANCE PROGRAMS: An Overview for Employers** *by Bryan White*

AT-011 **OUTPATIENT TREATMENT OF THE ADULT ALCOHOLIC** *by Michael Jacobs*

AT-012 **DRUGS AND THE TEENAGER** *by Dana L. Farnsworth and Michael Jacobs*



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P-151 **DIAGNOSIS AND TREATMENT OF ALCOHOLISM FOR PRIMARY CARE PHYSICIANS** **$1.95**

A 36 page handbook on alcoholism developed for the primary care physician in conjunction with the Ontario Medical Association. A "how-to" guide dealing with identification, diagnosis, short and long-term management in both the medical and psycho-social senses. Invaluable to the medical practitioner.

P-160 **TEN LESSON PLANS FOR GRADES 7 AND 8** **$7.95**
P-161 **TEN LESSON PLANS FOR GRADES 9 AND 10** **$7.95**

The program consists of two sets of 10 lesson plans. Each lesson deals with a separate topic and can be used independently. Developed in conjunction with the Toronto Board of Education. The lesson plans provide the teacher with as much information concerning alcohol and the process of teaching about alcohol as is possible. Includes suggestions for A/V and other materials to enhance the program. The Ontario Ministry of Education has reviewed the lesson plans and found them to fit Ministry guidelines.

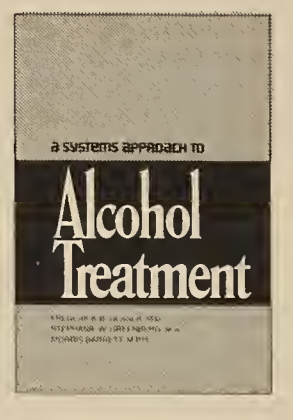


BOOK

A SYSTEMS APPROACH TO ALCOHOL TREATMENT

Authors: Frederick B. Glaser, M.D.
Stephanie W. Greenberg, M.A.
Morris Barrett, M.P.H.
$14.95

A major work which provides the results and conclusions on the system of alcoholism treatment programs within a large geographic area. The book provides a factual base from which to proceed toward developing a systematic alcoholism service delivery program. Will be of interest to administrators, organizational and policy personnel, and the general health care professional.



VIDEO CASSETTE

V-028 **MARIJUANA - THE FACTS** **$95.00**
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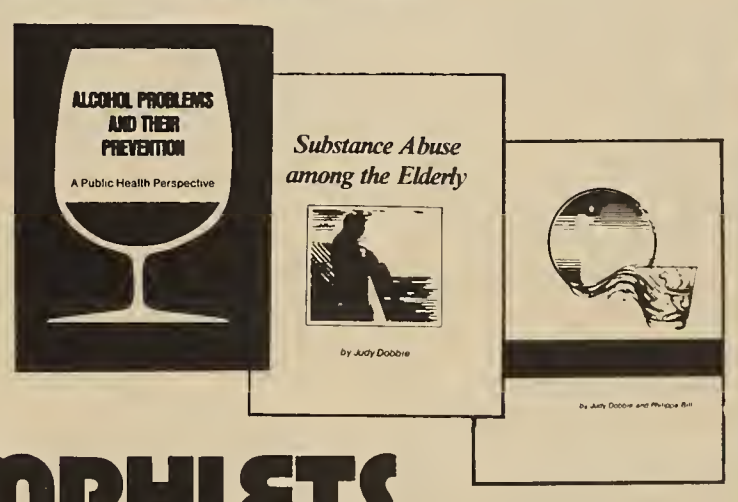
Target Audience: Teachers, social workers, health professionals, and general audiences of mid-teens and older. Especially useful in learning or teaching situations.

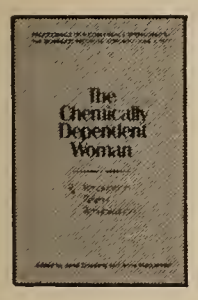
Content: What is marijuana and what does it look like?
Is it addictive?
Effects compared to alcohol?
Does use lead to harder drugs?
Would use be beneficial for particular medical problems?



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Proceedings of a two-day international seminar marking the designation of the Addiction Research Foundation as a collaborating centre of the World Health Organization.

Areas of discussion include: the epidemiology of alcohol and other drug-related problems, control strategies, and international collaboration in drug abuse programs.

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New Books

by RON HALL

Behavioral Tolerance: Research and Treatment Implications

. . . edited by Norman A. Krasnegor

The purpose of this volume, NIDA Research Monograph 18, is to share the information presented at the technical review held at NIDA in 1977 in order to stimulate further interest in the part played by non-pharmacological factors in drug tolerance and dependence. Past and present research findings on behavioral tolerance in substance abuse were presented; theoretical and experimental approaches to investigation in this field were compared and contrasted; an attempt was made to develop a working definition of behavioral tolerance as it applies to substance abuse; and possible new initiatives for investigating the concept within clinical research and experimental treatment research settings were discussed. Papers presented are grouped under the headings: narcotics, ethanol, marijuana, stimulants, and depressants.

(National Institute on Drug Abuse, 56000 Fisher Lane, Rockville, MD, 20857. 1978. 159p.)

The Office Treatment of the Alcoholic Patient: A Guide for the Physician

. . . prepared by C. Samuel Mullin

This manual is directed mainly to the internist, generalist or family practitioner, but can be of value to any physician who encounters problem drinkers in his practice. The guidelines include information on recognition of the alcoholic by the physician, recognition and acceptance of treatment by the patient, and psychotherapeutic principles and guidelines. A chapter on psychophysiological considerations covers alcohol and depression, withdrawal states, alcohol and anxiety, the use of sedatives, hypnotics, and disulfiram. Special mention is made of personality factors, the woman alcoholic, and the fetal alcohol syndrome. The appendices include the Michigan Alcoholism Screening Test (MAST), the CAGE test, and a self-knowledge test.

(Massachusetts Department of Public Health, Division of Alcoholism, 755 Boylston St, Boston, MA, 02116. 1978. 79p.)

Victims No More

. . . by Thomas R. McCabe

The author explains how family members may unconsciously perpetuate drinking, and it provides a step-by-step method of confronting the drinker and his destructive behavior. An examination of rational-emotive techniques shows how changing the way one thinks about drinking can result in a corresponding change in how one feels about it.

(Hazelden Books, Box 176, Center City, MN, 55012. 1978. 115p. $3.95)

Other Books

Drugs In The Classroom: A Conceptual Model For School Programs — Cornacchia, H. J. The C. V. Mosby Co, St Louis, 1978. Joint authors — D. E. Smith and D. J. Bentel. Society and drugs, psychosocial factors and the adolescent, the role of the community, the role of the school, appendix, index. 335p. $8.95.

The Impact of Alcoholism — Bucky, D. F. Hazelden, Center City, 1978. Signs and symptoms, medical aspects of alcoholism, personal and emotional aspects, legal aspects, interpersonal effects, effects of abuse on work performance, treatment attitude and behavior changes. 120p.

Behavioral Treatment Of Alcohol Problems: Individualized Therapy And Controlled Drinking — Sobell, M.B., and Sobell L.C. Plenum Press, New York, 1978. Nature of alcohol problem, alternatives to abstinence, functional analysis of drinking behavior, the early Patton studies, individualized behavior therapy — approach, new treatment evaluation measures, results, interpretation, private practice and outpatient programs, tables, bibliography, index. 225p. $16.95.

The Alcoholic Woman's Mad, Mad World of Denial And Mind Games — Kimball, B. J. Hazelden, Center City, 1978. Denial in all areas of drug dependence, the role of professionals, differences between psychic and physical dependence, relapse and self-esteem, effective intervention. 69p. $3.50.

Victims No More — McCabe, T.R. Hazelden, Center City, 1978. How family members may unconsciously perpetuate drinking, confronting the drinker, the family system in treatment, family system reorganizing. 103p. $3.95.

Drinking By Motorists — Institute for Road Safety Research, Swov, Netherlands, 1977. Report and results of roadside surveys into drinking and driving of Dutch motorists, tables. 71p.

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Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six point scale. For further information, contact Linda Chung, coordinator of the group at (416) 595-6150.

Francesca Baby

Subject Heading: Alcohol and the family.
Details: 46 minutes, 16 mm, color, sound.
Synopsis: Because of the mother's heavy drinking the responsibilities for the household have fallen upon the shoulders of the teenage daughter, Francesca. Her school work slips as a result. Francesca receives some pamphlets in the mail about Alateen. Although she rejects Alateen at first, she goes to a meeting and discovers her boyfriend is also a member. Realizing her mother's smoking in bed could lead to fire, Francesca devises a fire escape. When her mother sees what is happening, she is jolted into calling Alcoholics Anonymous.
General Evaluation: Very good (4.9). A highly contemporary, realistic, and technically well produced film with a clear message and strong emotional impact, it was deemed an effective teaching aid. The A/V Group liked what the film said about drinking, and felt it could help in decision making regarding alcohol use.
Recommended Use: Likely to benefit audiences of eight years of age and older.

Father/Son

Subject Heading: Alcohol and the family, attitudes and values.
Details: 15 minutes, 16 mm, color, sound.
Synopsis: This film is an intimately photographed dialogue between a father and his son. The son is concerned about his father's drinking and pleads with him to quit. The father tells his son about his dreams and aspirations, and his disappointment that they haven't been fulfilled. He tells his son it is perhaps his nature to drink, but the son still urges him to quit.
General Evaluation: Very good (4.9). A contemporary and interesting film with strong emotional impact, this technically well produced film was deemed an effective teaching aid. Its length was considered suitable for most educational uses. The A/V group felt the film could produce attitudes opposed to drug abuse, and could help in decision-making regarding drug use. Public broadcast was recommended.
Recommended Use: Likely to benefit audiences of 12 years of age and older.

Nobody Will Notice

Subject Heading: Trigger film; alcohol and the family, youth and alcohol.
Details: 2½ minutes, 16 mm, color, sound.
Synopsis: While his mother is busy making a cake in the kitchen, a boy is pouring some liquor from his parent's liquor supply into a bottle. Hiding the bottle in his coat, he leaves with two friends. While housecleaning, the mother hesitates while straightening the bottles at the bar. We are left wondering about the meaning of her hesitation.
General Evaluation: Good (4.3). This contemporary trigger film could open many areas of discussion.
Recommended Use: With the presence of a resource person, the film could benefit adult audiences.

Alcoholism and the Family

Subject Heading: Alcohol and the family.
Details: 45 minutes, 16 mm, color, sound.
Synopsis: In this lecture, Father Martin explores how alcoholism affects the family. He believes alcoholism is not just another sickness of the drinker; it is a family problem, and all must get help together. He gives his views on what an alcoholic is, and why he affects his family so adversely.
General Evaluation: Fair (3.2). A contemporary film with emotional impact, it received moderate ratings in all the other categories such as effectiveness as a teaching aid, clarity of message, informativeness, interest level, etc. The film could produce an attitude opposed to alcohol abuse, and could help in decision-making regarding alcohol use.
Recommended Use: Likely to benefit audiences of 15 years of age and older.

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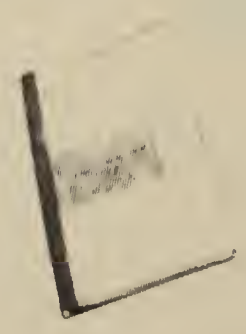
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Canada

Detox Training Program — Sept 11-15, Oct 16-20, Nov 27-Dec 1, 1978, Toronto, Ontario. Information: Mr G. Gooding, Assistant to the Coordinator, Detox and Rehab Programs, Addiction Research Foundation, 33 Russell St, Toronto, Ont, M5S 2S1.

Alberta Alcoholism and Drug Abuse Commission Summer School on Alcohol and Drugs — Sept 22-23, 1978, Kananaskis, Alta. Information: Marg Bailey, AADAC Community Extension Services, 2nd floor, 812-16th Ave SW, Calgary, Alta, T2R 0T2.

The College Of Family Physicians Of Canada (Ontario chapter) Annual Meeting — Oct 16-18, 1978, Toronto, Ont. Information: Marcia Barrett, 4000 Leslie St, Willowdale, Ont, M2K 2R9.

Canadian Psychiatric Association Annual Meeting — Oct 18-20, 1978, Halifax, Nova Scotia. Information: Dr A. Cote, secretary, Canadian Psychiatric Association, Suite 103, 225 Lisgar St, Ottawa, Ont, K2P 0C6.

United States

Health Care Evaluation In A Chemical Dependency Unit — Sept 11-12, Oct 16-17, 1978, Center City, Minnesota. Information: Marilyn Brissett, Box 11, Center City, MN, 55012.

National Amphetamine Conference — Sept 16-17, 1978, San Francisco, California. Information: Stephanie Ross, Amphetamine Evaluation and Physician Training Project, 409 Clayton St, San Francisco, CA, 94117.

Alcohol and Drug Problems Association Of North America Annual Meeting — Sept 24-28, 1978, Seattle, Washington. Information: Lynn Buttorff, executive - assistant - to - director ADPA, Suite 204, 1101 15th St NW, Washington, DC, 20005.

30th Annual Scientific Assembly of the American Academy of Family Physicians — Sept 25-28, 1978. San Francisco, California. Information: Beth Robertson, American Academy of Family Physicians, 1740 West 92nd St, Kansas City, Missouri, 64114.

Substance Abuse Perspectives In The Northwest — Sept 27-28, 1978, Coeur d'Alene, Idaho. Information: Kathy Blackmon, Substance Abuse Program, 600 North Curtis, Boise, Idaho, 83720.

Nursing Role In Chemical Dependency — Sept 25-26, 1978, Center City, Minnesota. Information: Marilyn Brissett, Box 11, Center City, Minnesota, 55012.

The Treatment and Rehabilitation of The Alcoholic — Oct 1-6, 1978, Savannah, Georgia. Information: Dr Bernard M. McGahee, 12506 Cranwood Lane, Savannah, GA, 31406.

American Association For Automotive Medicine — Oct 3-6, 1978, Louisville, Kentucky. Information: AAAM executive-secretary, PO Box 222, Morton Grove, Illinois, 60053.

Association of Labor-Management Administrators And Consultants On Alcoholism Annual Meeting — Oct 4-6, 1978, San Francisco, California. Information: ALMACA, Suite 907, 1800 North Kent St, Arlington, Virginia, 22209.

Substance Abuse Is More Than An Addiction — Oct 11-12, 1978, Cincinnati, Ohio. Information: Ann Blankenhorn, Alcoholism Consultant, 532 Maxwell Ave, Cincinnati, Ohio, 45219.

4th Annual Symposium On The Detection Of Drugs In Biological Fluids — Oct 13-15, 1978, Baltimore, Maryland. Information: Myron E. Shiplet, 640 Frederick Rd, Baltimore, MD, 21228.

Youth, Alcohol, And Social Policy Conference — Oct 19-20, 1978, Arlington, Virginia. Information: Gail Dickerson, Program Director, Health Education Foundation, 600 New Hampshire Ave NW, Washington, DC, 20037.

Family Service Association of America North American Symposium on Family Practice — Nov 1-4, 1978, New York City. Information: FSAA, 44 East 23rd St, New York, NY, 10010.

New York State Association For Human Services — Nov 20-21, 1978, New York City. Information: Family Service Association of America, 44 East 23rd St, New York, NY, 10010.

3rd Southeastern Conference On Alcohol and Drug Addiction — Nov 29-Dec 3, 1978, Atlanta, Georgia. Information: Conway Hunter Jr, Medical Director, Addictive Disease Unit, Peachford Hospital, 2151 Peachford Rd, Atlanta, GA.

National Organization For The Reform Of Marijuana Laws 7th Annual Conference — Dec 1-3, 1978, Washington, DC. Information: NORML, 2317 M St NW, Washington, DC, 20037.

Abroad

32nd International Congress On Alcoholism And Drug Dependence — Sept 3-8, 1978, Warsaw, Poland. Information: International Council On Alcohol and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

3rd World Conference Of Therapeutic Communities — Sept 17-22, 1978, Rome, Italy. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Representation Of Alcoholism In Cinema And Television — Sept 25-29, 1978, London, England. Information: The Secretary, Representation of Alcoholism Course, Alcoholism Education Centre, The Maudsley Hospital, 99 Denmark Hill, London, SEA 8AZ.

International Symposium On Alcoholism And Drug Dependence — Oct 16-20, 1978, Sao Paulo, Brazil. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

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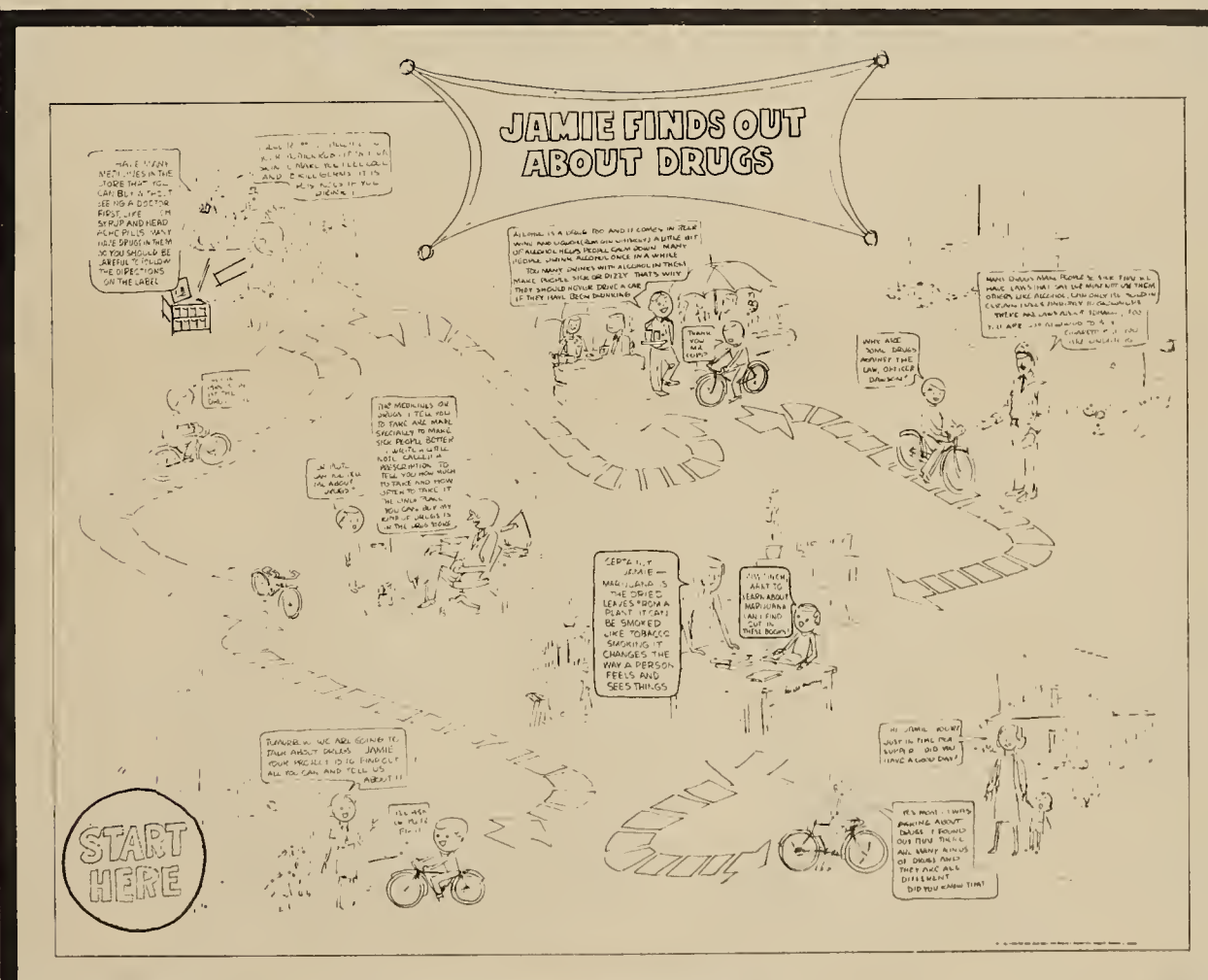
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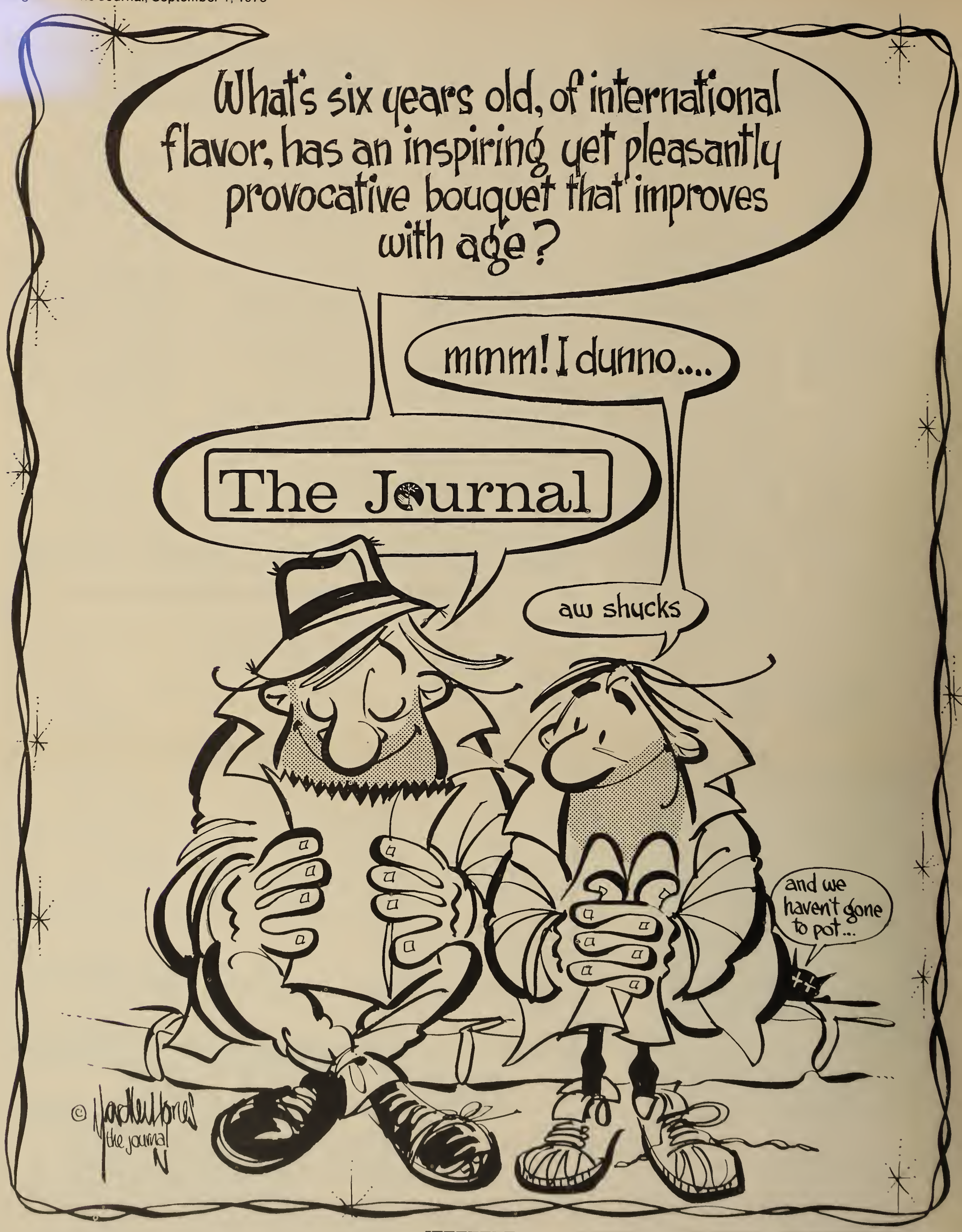
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PERIODICAL ROOM
Humanities & Social Sciences

Vol. 7 No. 10 TORONTO October 1, 1978

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

Canada's drug budget slashed

By Bryne Carruthers

OTTAWA — Federal support for experiments and research in the area of non medical use of drugs will be slashed heavily as part of the federal government's budget cutting exercise.

Treasury Board President Robert Andras, the man wielding the blood-stained axe through department after department, has sliced $4.8-million from the budget of the non-medical use of drugs program in the federal health department.

The move is the latest sign the federal government is downgrading its active involvement in the drug abuse area, especially in the research and development sector.

The budget reductions, to take place during fiscal years 1978/79 and 1979/80, will be taken from an overall budget of some $21 million for the agency for the two fiscal years.

Maureen Law, assistant deputy minister, health services and promotions branch, told **The Journal** almost all of the reduction will be from the grants and contributions part of the program — that is, the part used to fund research into drug problems, and to support demonstration projects into new types of treatment.

(Sources within the department say the cuts could have been worse, and that the whole grants and contributions budget could have been totally eliminated.)

The department is still trying to determine whether Non-Mudd, as it was called until a recent departmental restructuring, will also lose staff as well as research funding. (**The Journal**, September.)

Dr Law said the department must somehow eliminate 650 positions, and not all of these can be eliminated through attrition.

One advantage the former Non-Mudd group has going for it is its new, high-priority task of promoting health services. The staff are the core group now responsible for nutrition education, the promotion of lifestyles and other health matters, and family planning, along with the former task of drug-related matters.

While the department obviously wants the staff of Non-Mudd retained for these consolidated activities as part of a strengthened federal thrust in health services, it is clear from the budget-cutting the department and the government now

(See — Load — page 4)



Help!

Poland leads the world in alcohol consumption. It is also the only country to have made a cult of poster art as other countries have made cults of pop music, football, or fitness. Warsaw possesses the world's first poster museum and is the only city, apart from Vienna, to hold a poster of the month competition. Anyone can have a say in who wins simply by filling in a special newspaper coupon. As one writer has put it, for Poland posters have reached "the dizzy status of National Assets." Not surprisingly, the 32nd International Congress on Alcoholism and Drug Dependence in September in Warsaw was commemorated by poster artist Stanistaw Pudetko with the above poster — Pomocy — which, in English, is Help. A poster competition was also held in conjunction with the congress. Anne MacLennan reports next month from Warsaw.

ADPA joins exit from New Orleans

WASHINGTON — The Alcohol and Drug Problems Association of North America (ADPA) will hold a conference in the eastern United States in the fall of 1979 to replace a scheduled combined meeting in New Orleans with the National Drug Abuse Conference (NDAC).

The ADPA decision is the latest by groups and organizations, sparked by controversy over the Equal Rights Amendment, to dissociate themselves from the NDAC meeting in New Orleans (**The Journal**, May, August).

Augustus Hewlett, ADPA executive director, told **The Journal** the ADPA commitment to meet in New Orleans "was to the leadership and those minority groups and other specialist groups who have had leadership posts in NDAC in the past several years. It was not to an organization per se and for that reason, after all these organizations and individuals determined not to participate in New Orleans, the ADPA commitment was released in the minds of the board of directors.

"The board determined that it was in the best interest of all concerned that ADPA will not attempt to co-locate with NDAC '79 in New Orleans."

Mr Hewlett pointed out the idea of a co-located meeting with NDAC has been under consideration for some time. "We have been particularly impressed by the numbers and kinds of people who have been attending in recent years in the NDAC meetings. ADPA itself has striven to attract the entire spectrum of the field of drug abuse and to work in concert with the alcohol and other drug constituencies that are represented by ADPA."

Inside The Journal

Harold Kalant — Scientist in the courtroom Pages 7-10

Thomas Szasz — The lies of drug addiction The Back Page

British American Tobacco bats out with athletes Page 3

Non addictive pain killers: No easy answer

By Betty Lou Lee

MONTREAL — Endorphins — the body's morphine-like analgesics — aren't proving to be an easy answer to the quest for a non-addictive pain killer, but they may explain why acupuncture works for some people, and the basis for the placebo effect in pain relief.

Some promising preliminary findings also indicate there may be a way to prolong the normally short life of these endogenous pain killers, and heighten their effectiveness.

Endorphins were a major topic among the 400 research papers presented at the Second World Congress on Pain here. Since their discovery three years ago, they have opened up a new aspect of pain investigation.

When endorphins were first discovered, it was hoped they could be administered instead of morphine without being addictive, but this has not been possible. With long term exogenous administration, they are addictive.

But a group at the Chicago Medical School has found the amino acid D-phenylalanine interferes with the enzymes which quickly break down the endogenous endorphins, giving better pain relief. Long term experiments on mice showed no addiction or other undesirable side effects, Dr Seymour Ehrenpreis reported.

In the initial nine human patients on which this technique has been used for a wide range of chronic pain, there has been long lasting analgesia. A whiplash patient got a month's relief from three days' treatment, and a man with low back pain could tie his shoe laces and walk a mile.

There are no signs of withdrawal when the compound is stopped, and no evidence of tolerance. Patients appear to need less, rather than more, with time.

When naloxone, a morphine-inhibitor that works by occupying the morphine receptors on cells, is given to these patients, their pain returns.

Naloxone, and measurement of endorphins in the cerebral spinal fluid have become the standard techniques for investigating endorphins.

It has been found that endorphin levels are raised among people who respond to acupuncture, but naloxone can counteract the analgesia.

Dr J. E. Levine, University of California, San Francisco, presented findings that showed raised endorphin levels in people who responded to placebos for pain relief. He had no explanation as to why an inert substance would stimulate release of the endorphins. In his tests, as well, the effect was blocked by naloxone.

A French team tested a woman with congenital indifference to pain, and concluded her insensitivity was due to a hyperactive endorphin system. When an electrical stimulus was applied to the ankles of normal volunteers, they felt a pinprick sensation in the thigh at 10 milliamps, but the woman didn't feel it until 50 milliamps. Given naloxone, this dropped to 15 milliamps, but 20 minutes later rose again to 50.

Dr Henry Dehen of Neaujon Hospital, Clichy, France, said the woman's insensitivity to pain was not known outside the family until she was 31 because she was mentally retarded (a common condition with congenital insensitivity) and had been kept secluded at home. In hospital, she burned her hand severely because she didn't remove it from a heater.

Although Drs Margareta Erikson and Bengt Sjolund, Lund University Hospital, Sweden, found that acupuncture techniques raised endorphin levels, transcutaneous nerve stimulation of high frequency didn't, even when it relieved pain.

Hypnosis for pain relief also doesn't appear to work through this mechanism, since the endorphins aren't raised.

Dr Lars Terenius, University of Upsala, Sweden, measuring endorphins in patients at a chronic pain clinic, found those with pain from nerve damage had low levels, and those with psychogenic pain had high levels.

He suggested further investigation of these findings might lead to a test that would indicate which patients would respond best to the many different types of pain treatment available.

These and other endorphin reports lay scattered around the meeting like pieces of a jigsaw puzzle, and Dr John C. Liebeskind, University of California, Los Angeles, said there were still lots of pieces to come.

Three different endorphins have been discovered and there are probably more. Each is different chemically, and their distribution is different. Practically nothing is known about the mechanism that triggers their release.

It isn't even known if analgesia is their main function. Pain relief from narcotics, for example, involves not only pain inhibition but a pleasant euphoria and muscle relaxation, Dr Liebeskind said.

'Raisins' d'etre

HAMILTON — Never underestimate the ingenuity of an alcoholic.

Every day, the man came to his job in an industrial plant cold sober. And every day, by quitting time he was bombed.

Supervisors searched his lunch pail. They searched his locker. They searched the areas he worked in. No bottle.

Then someone remarked about his penchant for eating raisins, and the jar of them he always kept at his bench was examined.

He had discovered that raisins absorb seven times their weight in alcohol, and merely saturated them with it before bringing them to work.

This was one of the examples of alcoholic deviousness used by Jim Brechin of the Canadian Labor Congress at the Institute of Addiction Studies here.

Social patterns of 60s cited

Smoking declines in Britain

LONDON — The proportion of adult male cigarette smokers has fallen by 20% in Britain during the past 30 years while the proportion of adult female smokers has shown little change.

This is shown by a summary of Tobacco Research Council statistics published by Canadian researcher Peter Capell in the department of Health and Social Security review *Health Trends* (No 3 Vol 10).*

He says the decline in male smoking in the 1960s was accompanied by the emergence of a marked social class gradient, with class one smoking the least, and class five the most.

An increase in the rate of giving up smoking, and a decrease in that of taking it up had both contributed to the general decline in prevalence, with the former having the greatest effect.

Despite this general decline in prevalence, the number of cigarettes sold in Britain rose fairly steadily to a peak in 1973. However, the changing patterns in the 1960s, particularly the change from plain to filter cigarettes, resulted in a fall in the total weight of tobacco sold as cigarettes from a peak in 1961.

Since 1973, total sales in terms of both weight and numbers had fallen each year. But the consumption of cigarettes per smoker had increased substantially during the past 25 years, particularly for women (from about 50 cigarettes to about 120 per week) and more noticeably for the 16 to 34 age group than for older smokers.

"In terms of the health effects of cigarette smoking it is encouraging that over the past 10 years the average tar yield for cigarettes sold has fallen substantially, and between 1972 and 1977 the proportion of sales of cigarettes in the two lowest tar groups combined (low tar and low-to-middle tar) has increased from 5% to 21%," the report concludes.

**Health Trends, a quarterly review for the medical profession issued by the department of Health and Social Security and the Welsh Office. Inquiries to 6, St Andrew Street, London EC4A 3AD tel 01-353-2090.*

French screen roads, net drunk drivers

By Lynn Payer

PARIS — A tough new law permitting roadside screening for drunk drivers is being implemented in France.

People whose blood alcohol level exceeds 80 milligrams per 100 millilitres will be subject to fines, imprisonment, and loss of their driver's licence. If the driver has caused a serious accident, and the blood level exceeds 1.2 grams per litre, the driver's licence will be revoked.

Enforcement has been launched with a series of roadside screenings announced in advance and highly publicized. This approach was taken, according to Jean Beyrand of the Comité Interministériel de la Securitè Routière (Interministerial Committee for Road Safety) because "we couldn't just stop people who had never heard of the law, force them to take the alcohol test, and then take away their licences."

According to Mr Beyrand, a recent survey showed 97% of the population was aware of the law, and 66% approved of it.

While distillers in the south of France have threatened to prevent screening there, in Mr Beyrand's opinion such actions are local, epidemic, and not significant. (Each screening is authorized by a local judiciary.)

One reason for the widespread public support, he suggested, is a recent study by Professor Claude Got (**The Journal**, April) showing 40% of drivers in fatal accidents in France had a blood alcohol level above the legal limit. This, combined with other information showing only 4% of all drivers exceeded the legal limit, "convinced people that 4% of the drivers were responsible for 40% of fatal accidents, and of the role of alcohol in traffic deaths," Mr Beyrand said.

Restaurant owners and liquor salesmen in the areas where alcohol screening was announced reported drops in alcohol sales of as much as 80%. Mr Beyrand, doubts the law will produce an overall drop in French alcohol consumption, however. "Most of the countries with strict drunken driving laws still have high alcohol consumption," he said, "although there is a modification in the way they consume alcohol."

It's too early to judge the effect of the law on traffic accidents and deaths. Mr Beyrand said that in July — the month the law was published — there had been fewer traffic deaths than in a number of preceeding years.

The Watergators never knew paranoia like this

By Wayne Howell



If one accepts the public statements put out to explain the departure of Peter Bourne at face value (from his position as special advisor to United States President Jimmy Carter on health matters) then some rather disturbing questions have to be faced.

For instance, we are told Dr Bourne wrote the fateful prescription that was his undoing because Ellen Metsky, his administrative assistant, was afraid to go to an "outside" psychiatrist as she feared the visit would get on her record. What record could *she* have been thinking about? The record that is compiled from taps on private psychiatrists' telephones? The record that is compiled from the routine perusal of private psychiatrists' files?? The record that is compiled from reports of treatment activity on low-level White House staff that are submitted daily by private Washington psychiatrists???

If a White House aide cannot consult a private physician in a city of almost three million people without fearing the information will get on her government record then the Democrats have got the city wired in a way Richard Nixon and his Watergators never dreamed of — their surveillance organization was so primitive they had to break into psychiatrists' offices to get the goods on parties that interested them.

Of course it was not the prescription that did Dr Bourne in; it was his decision to use a phoney name on the prescription. We are told Dr Bourne felt this was necessary to protect Miss Metsky's confidentiality, to prevent her use of sleeping pills from getting on the record. What record could *he* have been thinking about? The record that is compiled from the routine inspection of the files of neighborhood pharmacists? The record that is compiled from the daily reports on drug use among low-level White House aides that are routinely submitted by all pharmacists in the Washington area?? One can almost hear John Dean saying, "what a wonderful idea".

There is, of course, the possibility that both Ms Metsky and Dr Bourne felt they had to act as they did because of a misinterpretation of the potential threat to Ms Metsky's career; they acted out of paranoia in other words. But even if this assumption is correct then other disturbing questions come to the fore. What is it about the present administration that makes people in it feel they are beign watched? If *they* feel that way how should people who are not in the administration feel?? And how should people who are known to be opposed to the administration feel???

Of course all these questions only arise if we accept the explanations at face value. Which I suppose we have to do. After all, this is the administration that promised never to lie to the American people.

(Wayne Howell is an Ottawa physician and freelance writer.)

NZ sports clubs call foul play on liquor licensing



New Zealand rugby players build up a thirst — but the bar is closed.

By Pat McCarthy

AUCKLAND, NZ — Maybe the Battle of Waterloo was not won on the playing fields of Eton, but to hear some rugby administrators tell it, the survival of New Zealand's way of life depends on profits from sports club bars.

Slygrogging in sporting clubs is indeed a long established national custom. Surveys indicate that every week more than 300,000 New Zealanders — 10% of the total population — drink on club premises, most of them illegally.

Premises vary from primitive to palatial. Most clubs make a token gesture to the Sale of Liquor Act by using tickets instead of cash, or lockers where members are supposed to store their drinks. Bar profits provide facilities, sports equipment, and uniforms.

Unless someone complained of rowdy behavior, police have tended to turn a blind eye. But now the clubs are under the eye of the law in such a way that they can be overlooked no longer.

Under new legislation designed to regulate the sporting speakeasies, clubs may seek licences from the Licensing Control Commission, the statutory body that supervises hotels.

More than 1,100 clubs, covering a score of sports, have applied for licences. Though most will receive them — making licensed sports clubs as numerous as hotels and taverns — strict conditions attached to licences granted so far have the sporting fraternity crying foul.

Bar hours provide the main arena for complaint.

Bowlers, accustomed to the clink of glasses preceding the clink of pins, are unhappy that they are not allowed to drink before 9 am — the pre-game snort is out.

Cricketers complain that a match may finish unexpectedly in mid-afternoon but their bars are not permitted to open until 5 pm.

A soccer administrator laments that the new licences will break down the "family spirit" of clubs with men's, women's, and junior teams. "The mums and dads have always been able to have a drink on Saturday nights while the kiddies play at the other end of the clubhouse," he said. "If we get a licence, we won't be able to let the kids stay and that means mum will probably have to go home too. The club will then become just another place where men stand around drinking and swapping jokes."

Rugby players are upset that the 7:30 pm to 9:30 pm bar hours allocated for training nights during the week will mean curtailing training sessions to fit in drinking time — or else going later to the local pub.

But rugby clubs are most bitter over their Saturday hours, from 4 pm to 7:30 pm or, in rare cases, 8:30 pm.

When one club's appeal to the Supreme Court failed, rugby officials painted a grim picture of financial hardship if they had to comply with restricted drinking hours. Falling bar profits, they said, would reduce the number of teams a club could put on the field.

To one disappointed administrator, the court's decision would "affect the New Zealand way of life" — a situation which one newspaper described as a case of a "thirsty tail wagging an athletic dog".

The Auckland Rugby Union, which is taking another appeal to the Supreme Court, predicted that "the capacity of rugby to recruit and retain players will be considerably diminished".

Whatever rugby's capacity, no one was underestimating the capacity of thirsty New Zealand sportsmen and their supporters.

In preparation for their new legal status, some sports clubs ordered 125-gallon or 250-gallon beer storage tanks. A bowling club with 250 members is reported to have installed three 125-gallon tanks.

But not all applications for licences have been granted. A rugby club was turned down because it took insufficient action over an incident in which a 16-year-old youth got drunk on its premises. A speedboat club was refused a licence after the commission heard about "wild drunken parties" in its clubhouse at Bottletop Bay.

The licensing of sports bars has had repercussions for the general licensing system. After 60 years as a "dry" area, Auckland's Mt Roskill borough received its first legal liquor outlets when local sports clubs were licensed. And the approval of Sunday drinking for clubs with sports activities on that day has led to murmurings from the hotel industry for similar concessions.

In a bid to ensure year-round drinking facilities, some rugby and other winter-sport clubs have formed associations with a summer sport, such as cricket. But that ploy, the commission has ruled, just isn't cricket.

"As we see it, a member of a rugby club who is not an active member of the cricket teams playing under the club's name cannot have access to the drinking facilities of the club unless he is an invited guest," the commission said. "We consider that the number of invited guests must be in realistic proportion to those actively participating in cricket . . . ."

Because of the restrictions imposed, many clubs are refusing to operate their new licences, preferring the risky ticket or locker systems of old. (Exchanging liquor for pre-purchased tickets is just as illegal as using cash; a locker system is legal only if each member's alcohol is bought elsewhere and stored in his personal locker.)

Meanwhile, a private member's bill to ease the restrictions has come before Parliament and is being considered by the statutes revision committee.

Rugby, racing, and beer are said to be New Zealanders' most popular pursuits. When bowling, cricket, tennis, badminton, softball, squash, golf, and others are added, they could ferment a potent brew for politicians to imbibe in this election year.

British American Tobacco bats out with athletes

By Alan Massam

LONDON — British athletes have rejected angrily the promotional activities of a leading tobacco company, stressing few of them smoke, even occasionally, "because . . . it would bring . . . sickness, chronic ill health, and premature death."

The attack, sponsored by the International Athletes Club to coincide with the opening of the Commonwealth Games in Edmonton, is aimed at British American Tobacco.

Among those masterminding a series of press conferences and a large advertisement headed "Get Out of Athletics British American Tobacco" published in *The Times* of London was long distance running star David Bedford.

He told **The Journal**: "I am very pleased to say that our athletes don't want themselves or their sport subverted by tobacco interests, nor do they want BAT using their names and achievements without their permission. The International Athletes Club could not sit back and see athletics succumb. If athletics were to go under to tobacco exploitation, the door to the Olympic Games would be wide open: we could see an appalling smoking junket."

Chairman of the IAC, Derek Johnson, said: "I am proud of the way in which our athletes have reacted to this attempt to exploit our sport. It was vital to take action as soon as possible to prevent any exploitation of the forthcoming European championships. With this level of opposition from within the sport it seems inconceivable that State Express (the brand promoted by BAT) should attempt to stay in athletics. It would show the most tremendous contempt for the athletes concerned."

The anger of the athletes has been fueled by the introduction of the so-called State Express Challenge in Britain to back the relaunching of the brand name here. This challenge puts up stake money to certain sports if British sportsmen and women attain specified targets.

The promotion has been criticized widely in the House of Commons, but the company has proceeded on the grounds the campaign is "sports sponsorship" not tobacco advertising, and therefore permissible.

In their half-page advertisement in *The Times*, the International Athletes Club stresses the British advertising code of practice relating to cigarettes states advertisements shouldn't feature heroes of the young or imply that smoking is associated with success in sport. Nor should it depict people participating in any active sporting pursuit.

"State Express of London's 'Challenge to Britain's Sporting Greats' is not subject to these restrictions because it is a form of sponsorship advertisement to which less stringent restrictions apply," the IAC statement goes on.

"By leaving out the full brand name and by showing silhouettes of immensely successful sportsmen and women, together with a backcloth of officials and spectators at the Munich Olympic Games, State Express has complied with the technical requirements of the sponsorship code of practice, but in our view this is an overt attempt to link success in athletics with smoking.

"Running, above all, requires the highest respiratory and circulatory efficiency, and we consider this promotion a disgraceful and degrading abuse of our sport.

"Members of the International Athletes Club, past and present, including those selected to represent their country in the Commonwealth Games and European Championships, have overwhelmingly dissociated themselves and their sport from this scheme.

"Many of our members, through our Convention Against Smoking by the Young, have pledged themselves to support the campaign against smoking."

The IAC statement then goes on to drive home some of the "facts about smoking" including references to the risk of cancer among smokers; the fact the Royal College of Physicians estimates 50 million working days a year are lost through smoking, and the government statistics which suggest the habit causes 50,000 premature deaths in Britain every year.

It concludes: "We believe that a continuance of this promotion will represent a betrayal, not only of athletics, but also of the efforts made by the department of health . . . and the medical profession generally to diminish the ills of smoking. We demand that British American Tobacco and State Express of London get out and stay out of athletics.

"We call upon the Prime Minister and the Minister for Sport to terminate this cigarette company's promotion at the earliest opportunity."

When questioned about his reaction to the attack the British Minister for Sport, Denis Howell, said he didn't want to make any comment as it was his intention to "play it cool." Tobacco company promotion is believed to be worth vast sums to the organizers of some sporting events.

Similarly, the British American Tobacco Company declined to enter the fray apart from emphasizing that they regarded the State Express Challenge as legitimate sport sponsorship.

**International Athletes Club: 1, Verulam Buildings, Verulam St, London WC1 X8LZ. (Tel: 01-242-0681 ext 42)*

Russian in the swim over steroids

WEST BERLIN — A Russian backstroke swimmer was stripped of his bronze medal won in the World Swimming Championships here when a random urine test later showed he had been taking anabolic steroids.

Vladimir Kuznetsov, 17, had competed in the 100 meters backstroke. This is the first proven case in international swimming of the use of anabolic steroids by a competitor.

Meanwhile, British shot putter Geoff Capes had been rapped by his national association because he claimed many East European field event competitors use anabolic steroids during training, and stop just before international competition.

Mr Capes, who was unplaced, said he was attending the European Games in Prague under protest. He said it was well known East European athletes used steroids in training, but nothing was done about it.

Dependence, illicit use make two drugs controlled

Appetite suppressant is suppressed

By Betty Lou Lee

HAMILTON — Regulatory changes that tighten controls on certain drugs may mean more legal problems for people misusing amphetamine-like drugs, and a search for alternative sedative-hypnotics by alcoholics.

Joan Marshman, head, pharmacological services, Addiction Research Foundation of Ontario, said diethylpropion and methylphenidate have been moved from Schedule F (prescription use) of the Food and Drug Act to Schedule G (controlled drugs) because too much was being diverted to illicit use from licit pharmaceutical manufacturers.

Diethylpropion is marketed as an appetite suppressant, and although less active than amphetamine as a central nervous system stimulant, has similar effects. Methylphenidate, also related to amphetamine, is primarily prescribed for narcolepsy and minimal brain dysfunction in children.

Dr Marshman said these drugs' illicit use increased with tighter controls on amphetamines, and now will be subject to detailed record control at all levels — manufacturer, wholesaler, pharmacist, and physician.

While this will reduce diversion to the illicit market, it will also create more legal problems for users, she told the Institute on Addiction Studies here.

A number of non-prescription sedative-hypnotics such as Nytol and Sominex have also been added to the prescription list because they contain bromide salts or calcium bromolactobionate and their chronic use can lead to a sometimes fatal bromide intoxication. (Bromides were also removed from Bromo-Seltzer because of this regulation.)

"We must acknowledge, with 20/20 hindsight, that for years we have been making freely available products to which psychological dependence could readily develop, giving rise to chronic use and damage to physical and mental health," Dr Marshman said.

Many chronic users of these products are alcoholics who used them to "steady their nerves" during withdrawal.

"It is therefore reasonable to expect that such individuals will now seek other alternative drugs, even when this means consultation with a physician in order to secure prescriptions for a benzodiazepine or barbiturate."

Dr Marshman warned against the use of anti-anxiety agents like the benzodiazepines (Valium, Librium) without concomitant treatment to change the life situation which produced the anxiety.

These drugs may be helpful to "buy time" for other forms of therapy, but by themselves can worsen the situation because removal of the anxiety can lead the patient to turn a blind eye to his problems and allow his situation to deteriorate.

There is good evidence that even short term use for alcohol or drug-dependent people "without very careful supervision is probably high risk behavior". And Dr Marshman said there is also the possibility, as yet unsubstantiated, that the usual therapeutic doses may have adverse effects on some individuals:

"For example, concern has been expressed about the possible role of anti-anxiety drugs in child abuse problems, possibly because of so-called paradoxical aggressive reactions."

Dr Marshman also said widespread cannabis use presents some risk to both the user and those in his "interactive environment". She cited the deficits in coordination skills it can produce, and the possibility of impaired driving. With the lack of technology to produce a "marijuanalyzer" similar to the Breathalyzer for alcohol, there is no way to hold such drivers accountable for their impaired driving.

"It is specious to suggest that cannabis should be made as readily available as alcohol because it presents no greater risk, and perhaps even less risk. If alcohol were not a part of our culture, but were being introduced in the 1970s, I am convinced it would not be accepted either as a drug available without prescription, or as a beverage, in light of the available evidence which identifies it as a substantial health hazard."

British youth pop 'crazies' legally

LONDON — A drug prescribed widely in Britain for slimming has become the latest craze among young people looking for kicks. It is diethylpropion, (Tenuate), containing neither barbiturate nor amphetamine, but capable of stimulating the central nervous system.

The trouble for drug enforcement officers is the drug is not among those covered by the 1971 Misuse of Drugs Act, and therefore, is perfectly legal.

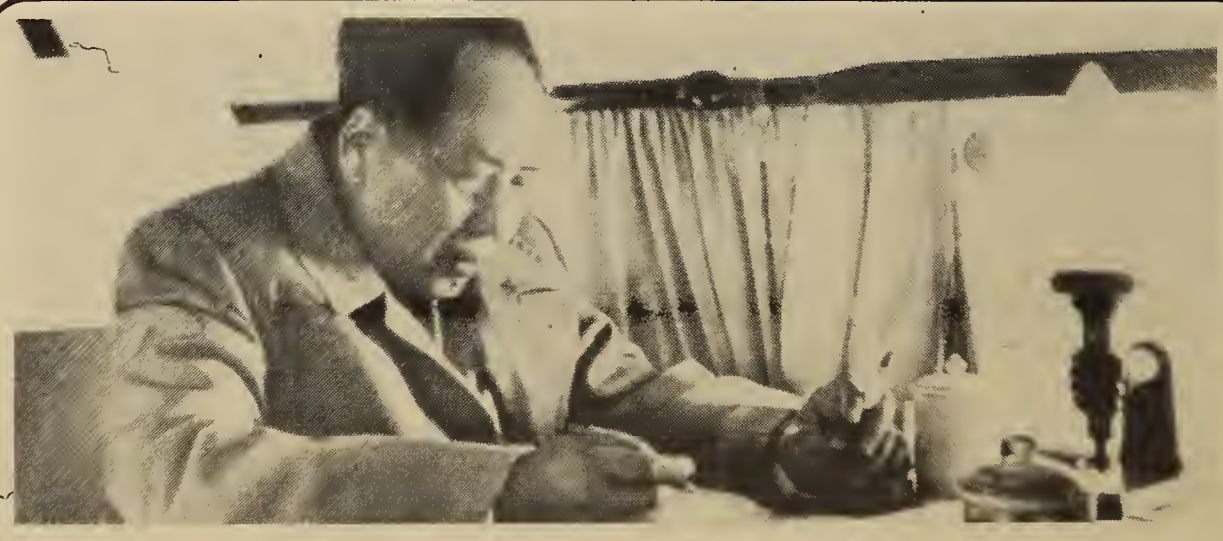
Police are worried because they believe the stimulant is being produced at several London backstreet pharmaceutical "factories" to sell on the street at about £1 for three tablets. Unauthorized drug production is illegal, whatever the substance involved, but tracking down these entrepreneurial chemists is a notoriously difficult task.

On the streets, diethylpropion pills are known as "crazies" and produce unpleasant side effects for the majority of users. A spokesman for the police drugs squad in London reported frustration because officers were asking young people found to be in possession of the pills if they would authorize the police to retain them. Otherwise, the pills had to be handed back.

"We want to find out where they are being produced and stop them at source," he said.

A Home Office representative said the problem might be handled by putting diethylpropion on the list of prohibited drugs. He said this course of action was being considered.

Smoking glamorous in China



The late Mao Tse-tung: His cigarette habit was admired.

HONG KONG — A simple advertising technique boosted the manufacture of cigarettes to at least 725 billion this past year in the People's Republic of China — 60 billion more than the United States.

That technique is widespread and visible smoking by political leaders combined with the deep-seated training of the Chinese people to emulate those in authority.

But now there are signs that Peking intends to convince the country's 90 million smokers that smoking may be hazardous to their health.

In an article in Peking's *Kwangming Daily*, two distinguished Chinese doctors wrote that cigarettes may have some connection with bronchitis, emphysema, throat and lung cancer, hypertension, and heart disease.

The visibility of smoking leaders such as the late Mao Tse-tung, his successor, Hua Kuo-feng, and Vice Chairman Teng Hsiao-ping, appears to be behind an increase in smoking by the country's young people.

"To counter this trend, we will mount an education program that will enlist the support of teachers and parents..."

The campaign, low-keyed at the moment, will meet significant obstacles. As Chinese leaders continue to smoke before the public, the state tobacco industry does a booming business at home and abroad.

And if successful, the campaign would cut into large revenues generated by a 60% tax collected on each pack of cigarettes.

Urged to attend Alcoholics Anonymous

Lawyers help their alcoholic peers

SEATTLE — A volunteer group of recovering alcoholic lawyers and judges in California has been so successful in helping colleagues with drinking problems it now wants the organized bar to finance the program.

Judge Leon Emerson, chairman of the alcohol abuse committee of the California state bar, said the positive action for lawyers (PAL) system "has assisted several hundred lawyers in their personal rehabilitation."

Just as important, it has helped make amends to clients harmed by actions of their alcoholic lawyer. "Although the records are ultra confidential, money returned to clients, insurance companies, and creditors runs into hundreds of thousands of dollars."

Judge Emerson told the annual conference of the Alcohol and Drug Problems Association of North America the lawyer with a drinking problem can hurt himself and his clients in a number of ways.

The lawyers fail to keep appointments, are late for court appearances, let work on pleadings and briefs slide, and often let the statute of limitations run out in particular cases.

The lawyers start "borrowing" from trust funds, and engage in other financial misdeeds.

The committee was set up with an extremely small budget and the members work on a volunteer basis.

The alcoholic lawyer who becomes part of the program is assigned three members of PAL "who are willing to work on the positive-peer approach to determine what the best program would be for this particular victim," Judge Emerson said.

"PALs do not mother, smother, or do anything for the victims that the victims cannot do for themselves," he said. "They do not appear in court, act as a lawyer before the disciplinary authority, pay or guarantee their bills or obligations, or excuse them from any of their transgressions."

PALs meet weekly and each lawyer with a problem is encouraged to attend Alcoholics Anonymous. Some PAL meetings allow wives, secretaries, and doctors to attend.

Judge Emerson said a pilot program has been worked out with the state bar for an informal probation system for the lawyer or judge undergoing a disciplinary proceeding. In essence, the system allows a consultant to evaluate the problem, call in PALs for assistance, and make a final report to a referee who, in turn, sends a report to the state supreme court, which has ultimate disciplinary authority.

Judge Emerson said the program is considered a "post-conviction" and not a "diversion program". It does not interfere with, or slow down, disciplinary actions.

He said through the success of the program "probably more money in past bar dues have been paid than the cost of the entire program. Taxes collected by government on increased earning of the members rehabilitated runs into very large sums."

Judge Emerson said the California bar association must now decide whether it will pay for the program. Adequate staff and secretarial assistance is needed to coordinate the action of the volunteers.

More next month from ADPA

Load to shift to provinces

(from page 1)

feel other jurisdictions (namely, the provinces) should be carrying more of the load in research and development in the drug abuse field.

Dr Law said most of the $4.8-million cut will be from next fiscal year, and none of the projects already approved or funded under the grants and contributions program will be affected.

However, there will be very little, if any additional money spent this fiscal year, and a lot less available next year.

Dr Law said the health and welfare department, wherever possible, tried to cut internally before reducing money available for outside programs.

Overall, the department managed to reduce its planned capital expenditures by 47% and its operating budget by 36%, leaving a required 17% reduction in grants and contributions.

Correction

About 10% of Canada's 300,000 military and civilian employees suffer alcohol related employment problems, and not 1%, as reported in the September issue of The Journal, according to the Department of National Defence.

Cold-blooded facts combat 'treatment myths'

By Betty Lou Lee

HAMILTON — Idealism and enthusiasm have brought the addiction treatment field a long way, but if it is to reach maturity, they must be tempered with realism and cold-blooded facts, according to Harrison Trice.

Dr Trice, senior professor, School of Industrial and Labor Relations, Cornell University, Ithaca, NY, has been associated with alcoholism studies for 25 years.

As part of his realism therapy, he told the Institute on Addiction Studies here to look at "some of the myths that have been hamstringing your efforts".

"It is almost inevitable that we attribute success to ourselves . . . We have to deal with the myth that trying brings results." It is a myth also that major results come from efforts by helping occupations. "That is not so. They are brought about by broad social movements, such as the present health and exercise movement among the young which is working against abuse."

Dr Trice said everyone working in the field is going to be subjected to program evaluation by researchers, and must learn to live with these assessments.

There is a "clear-cut myth abroad that if you have a 'program', and it's implemented, it can be carried out. But most of them get railroaded, deflected. The basic reality is that they aren't programs, but a twinkle in someone's eye . . . . It's rare to find a program that four or five years later is moving toward its original goal. It's hard to get on, and keep on the track because all sorts of compromises have to be made."

He said this applied to job-based programs as well as big treatment centres.

Organizations in the addiction field are subject to the myth they are somehow different than other workplaces because of their lofty goals, Dr Trice said. But they still must deal with staff morale, job satisfaction, and career opportunities: "They have a long way to go to manage an organization ... to understand employees and unions. Many don't know the front end of a union from the back end of a Mack truck."

This is true also with volunteers, Dr Trice said. They are employees who are paid in "psychic income." Their motivations and sources of satisfaction are different than paid staff, and there are different ways of keeping their morale high.

In spite of the myths, Dr Trice said there have been major advances in the addictions field in the past 25 years. It is attracting 1,000 times more resources, the idea of addiction being a moral disorder is diminishing, the stigma has been reduced, research patterns have been established, and there is less societal support for some addicting substances, particularly nicotine.

Confrontation not always best policy

EAPs: The problems and solutions

HAMILTON — Employee Assistance Programs (EAPs) dealing with alcoholism have been hailed as the wave of the future, but they have their shortcomings.

Some of the problems outlined at the Institute on Addiction Studies held here were:

- Most of these EAPs are designed by management without input from employees, and have one program for management and another for the bargaining unit, according to Jim Brechin, regional director of education for the Canadian Labor Congress and a member of its drugs and alcohol committee.

Mr Brechin has examined 1,400 EAPs in Canada and the United States.

- Many programs are only concerned with making sure employees are sober on the job, without any interest in long term treatment of alcoholic employees, Mr Bechin said.
- Programs that reduce the alcoholic worker's income while he is being treated "add another problem that can drive him back," he added.
- Confrontation by management with the alcoholic worker has its limitations for women, according to Heather Kilty, community consultant, Addiction Research Foundation, St Catharines branch. "Women aren't motivated by confrontation in the same way men are," she said. "They are more likely to give up their jobs, although this may change as they become more dependent on their salaries."
- Confrontation also often fails with young drug abusers, she said. The lever of job loss isn't as strong with them. There is also less interest by management in rehabilitating these workers, since it hasn't the same investment in a relatively new employee.

Confrontation

In recommendations for building stronger EAPs, Mr Brechin said an EAP should not be part of a collective agreement, other than a clause saying there will be an EAP committee representing both union and management. If details of the program are in the contract, they can't be changed during the contract, he said.

And if an EAP is part of the package on the bargaining table, it is too easily dropped.

Harrison Trice, senior professor, School of Industrial and Labor Relations, Cornell University, Ithaca, NY, said he has seen a growing tendency to "ship people right into treatment" without the confrontation stage, at which time their deteriorating performance is documented and shown to them, forcing the employee to make the decision to do something about his alcohol problem.

Options

Dr Trice, who has been studying employee programs for 25 years, said: "You have to describe in gutsy, eyeball to eyeball detail the way he's screwing up at work, and say, 'We don't know what's wrong, but maybe this program can help.' It's his option.

"The goal is to establish a motivating power within the workplace, to intervene, to give an option to get treatment, and to motivate it."

Alcohol beats all comers as 'ideal' addictive drug

HAMILTON — If some enterprising chemist set out to make the ideal drug for dependency, the one that would create the most thorough addiction, he would have to meet five criteria.

Super-drug would have to have a rapid capacity for tissue tolerance and dependence, with fast withdrawal distress. It would also have a capacity for psychological dependence, by providing a sense of well-being and temporary avoidance of frustration, tension, and anxiety.

It would be simple to manufacture, with a minimum of deliberate cultivation and processing, and it would be readily available. There would be no complex techniques involved in its use.

Harrison M. Triee, senior professor, Cornell University, Ithaca, NY, measured a list of substances against these criteria.

Opiates, including heroin, have a high capacity for physical and psychological dependence, but they aren't simple to manufacture and use, and there is no societal support for them.

Barbiturates also have high dependence capacity and are easy to use, but are difficult to make, and have no social sanction.

Acceptance of tranquillizers is quite high, they are easy to use, and they can create psychological dependence. But their capacity for physiological dependence isn't known, and their manufacture is complicated.

Marijuana can bring a psychological dependence, but no proven physical one. Its manufacture is simple, although learning to use it is more complicated than just swallowing a pill. Societal support is "rapidly mounting," Dr Trice said.

Nicotine meets all the criteria except simplicity of use — that involves a learning process. Caffeine's ability to cause physical dependence is hard to demonstrate. Amphetamines are hard to make, and have limited social acceptance.

Alcohol is the one substance already known that meets all the criteria, Dr Triee told the Institute on Addiction Studies here. Physieal dependence develops more slowly than with opiates or barbiturates, but it carries the danger of direct neurologieal and liver damage, whieh the opiates don't. It ean be manufactured anywhere fermentation will take place, and its societal support is even greater than that of nicotine.

Will lillies bloom in Thailand?

WELLINGTON, NZ — Prime Minister Rob Muldoon has made a personal contribution to the crop substitution program run by the King of Thailand in conjunetion with the United Nations.

A keen cultivator of lillies, Mr Muldoon has at his own expense sent 2,000 lily hybrid seeds to Thailand's Prince Bizidet, who runs the King's erop substitution project. Mr Muldoon's hope is that the prince will distribute the seeds to hill tribesmen as a substitution crop to opium poppy growing. Mr Muldoon grows his own lillies, is a recognized expert and authority on the plant, and was onee president of this country's Society of Lily Growers.



Rob Muldoon

The idea to send the lily seeds eame to him when he visited Thailand earlier this year. During a tour of hill tribe villages, Mr Muldoon noticed the tribes people were growing all kinds of plants from seeds — besides opium poppies — and were adept at hand-pollinating flowers.

He reasoned the villagers would have no problems producing the F1 hybrid lillies, a plant which fetches a princely price on the world horticulture market, especially in the United States. "They (the villagers) will get a far better return from lillies than from the opium poppy," said Mr Muldoon.

NZ officer in Bangkok

WELLINGTON, NZ — Conecrned at the increasing flow of hard drugs from Asia into New Zealand, the New Zealand government is to appoint a senior police official as an anti-drug officer at its embassy in Bangkok.

Holding the diplomatic status of first secretary, the officer will have the freedom and finance to travel anywhere in Asia, Minister of Police Allan McCready told Parliament.

Beer bears carcinogens

WASHINGTON — Small traces of nitrosamines, a carcinogenic agent, have been found in some American beers tested by the United States Brewers Association.

The association carried out these tests following reports from Europe that minute amounts of nitrosamine compound have been found in some beers at the level of two to three parts per billion.

The association said tests on American beers showed "similar minute amounts of about two to three parts per billion may be present in some beers." Attempts will be made to try to identify the source of the nitrosamines and eliminate them.

Elderlys' neglect increases alcoholism

HAMILTON — The elderly have replaced housewives as hidden alcoholics, according to John Hassan, Addiction Research Foundation, Scarborough branch.

Those men and women older than 60 are hidden because there is a tendency to neglect alcoholism among the elderly that mirrors the neglect of them in other areas, he told the Institute on Addiction Studies here.

Mr Hassan termed this neglect "agism". It has only been in this decade that researchers are beginning to study the extent of the problem, and whether treatment programs for the young and middle-aged are applicable.

He has begun recently to work with a public health nurse to help alcoholics in a 295-unit senior citizen high-rise, where the superintendent estimates 10% of all the tenants, and 20% of the singles males have drinking problems. The few studies done in the United States and Britain put the drinking problem rate at 5% to 19% in this age group.

Elderly alcoholics fall into two main groups, Mr Hassan said. One has a lifelong history of chronic drinking. "They may have cirrhosis, chronic brain disorders, and heart disease, but they have somehow survived." The second group may have been moderate drinkers all their lives, but start abusing alcohol because of life crises or environmental changes: mandatory retirement, death of a spouse and friends, boredom, reduced income, or a move from familiar surroundings.

Many doctors also deny the problem because they are unwilling or unable to do anything about it, Mr Hassan said. They don't have the time, skills, or a place to refer the patient, and if they document alcoholism in the record, it may mean the patient later won't be able to get into a nursing home.

Mr Hassan said there should be better coordination of services: "There's now an excess of them for senior citizens, fragmented and working at cross-purposes, with the right hand not knowing what the left one's doing."

EDITOR
Anne MacLennan

STAFF WRITER/PRODUCTION EDITOR
Karin Pargas

CONTRIBUTING EDITORS
Harvey McConnell (Washington)
John Shaughnessy (Toronto)

SCIENCE EDITOR
Dr Ruth Segal

The Journal

Published by Addiction Research Foundation of Ontario
33 Russell St, Toronto. (416) 595-6053

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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Letters to the Editor

Bourne's position must be filled

The people of this nation have lost an able and dedicated advocate for their health needs with the resignation of Dr Peter Bourne from the post of Special Assistant to the President (**The Journal**, August).



Peter Bourne

Perhaps those of us in the alcohol and drug abuse field have lost most. Dr Bourne is known and respected in international circles as well as in the United States.

It will be a tragedy if this position is left unfilled for very long. Given the current vacancies at high level positions in the national alcohol and drug abuse field, it is imperative that the post be filled as soon as possible.

We would encourage the administration to search for someone with the same kind of compassion and professionalism Dr Bourne displayed during his tenure. The momentum of his accomplishments in domestic policy and international cooperation on drug issues must not be lost.

William Butynski, PhD
President
Alcohol and Drug Problems Association of North America
Washington, DC



'Flaky, warped views'

Had an MD in the Baltimore area written a prescription for a controlled drug to a phony name, he would automatically have been charged with this serious criminal violation of the law. The "pot" lovers have lost a dear friend in Peter Bourne (**The Journal**, August).

The nicest thing I can say about Dr Thomas Szasz's continuing failure to recognize opiates, alcohol, or barbiturates (**The Journal**, August) addiction as a specific illness entity is that he could be committed.

These two men epitomize the "leadership" causing the substance abuse problem to worsen in our free societies, with your publication providing the forum to disseminate their warped, flaky, harmful views.

Alfred V. Miliman, J.D.
Director, Maryland Drug Abuse Research and Treatment Foundation, Inc
Baltimore, Md.

You're one of a kind

For over a long period of years I have been indebted to the Addiction Research Foundation of Ontario for furnishing me regular copies of the inimitable **Journal**, for which I am most grateful, and would take this opportunity to convey my sincere thanks.

However, I am no longer actively engaged in the field and I somehow feel it is not right that I continue to receive **The Journal** when I am sure it could be placed to better purpose with some person on the "front line" of the battle. I would therefore request that my name be deleted from your mailing list.

How fortunate is Canada to have manifested such excellence and leadership in the addictions field. Surely there is not another journal of the kind anywhere else in the world.

Harold C. Huggins
Ottawa, Ontario

BC and heroin

I've subscribed to **The Journal** for several years and note you carry reports on the muddled efforts of the British Columbia Government to regulate heroin use.

In addition to continuing all of the sadistic failures from the past, suppression, repression, prosecution, and punitive police action, forced treatment is the newest form of gestapo tactics to be forced upon the people of BC.

R. L. Foster
Chartered Accountant
Burnaby, BC

More letters

The comment piece A step backward for alcohol control (**The Journal**, April) by John Shaughnessy, was exceedingly appropriate and very well done.

The Journal will benefit from more such pieces.

Please keep up the good work.

Paul C. Whitehead, PhD
Chairman
Department of Sociology
University of Western Ontario
London

I thoroughly enjoy **The Journal**. The coverage and depth is outstanding. It keeps me up to date on world wide news.

Douglas G. Alexander
Public Information Officer
Washington State Liquor Control Board
Olympia, Washington

The California State Department of Alcohol and Drug Abuse is distributing approximately 90 copies of the article A Strategy for the Prevention of Alcohol Problems (**The Journal**, June).

We believe the article's recommendations need important debate.

Thank you for allowing us to distribute it.

Thomas L. Jones
Assistant to the Director
California State Department of Alcohol and Drug Abuse
Sacramento

I consider **The Journal** excellent — and with a broad range of needed information. Congratulations to the Editor and contributors.

Dr Jose Pozuelo
Cleveland Clinic
Cleveland, Ohio

Just a note to commend your fine organization on publishing, in my opinion, a well-researched and well-edited monthly paper on drug and alcohol use and misuse. I believe **The Journal** provides the best treatment of the subject of any that have come to my attention.

William W. Cormack
Denver, Colorado

The Journal welcomes Letters to the Editors. Letters bearing the full name and address of sender may be sent to: The Journal, 33 Russell Street, Toronto, Ontario, M5S 2S1.

The Journal

Harold Kalant: Scientist in court

Dr Harold Kalant, director of biological studies for the Addiction Research Foundation of Ontario, was asked recently by the United States government to offer expert scientific evidence on marijuana.

His testimony, as well as that from a number of other experts, is now under study by three US Appeals Court judges. They're expected to hand down the decision early next year on a suit brought by the National Organization for the Reform of Marijuana Laws (NORML) challenging the constitutionality of US laws covering marijuana.

Dr Kalant, who is also a professor in the faculty of medicine, department of pharmacology, University of Toronto, responded in detail concerning the manner in which scientists carry out their research, and how they draw conclusions as to the effects of the drug.

This month The Journal presents the direct examination of Dr Kalant by Allan P. MacKinnon, US department of justice. Next month, this edited series will conclude with the cross-examination.

Direct Examination

Mr MacKinnon: Is cannabis a toxic material, Dr Kalant?
I would say that every drug is potentially toxic material. Any drug which has a recognizable pharmacologic effect is capable of toxicity if given in high enough dosages over a long enough time.

And the question one wants an answer to, in order to qualify a drug as toxic or not, is how much is required to produce this effect and how many people are likely to use that much so as to experience those effects. In that connection, I would say in a number of ways, yes, cannabis is a toxic drug.

The Court: Are all toxic effects harmful?
That perhaps, Your Honor, is a semantic matter because "toxic" by definition means . . . it could have a harmful effect.

The Court: All right.

Mr MacKinnon: How do you find out whether a drug is toxic or what toxic effect it produces?
That depends in part on how serious the toxicity is. If the substance is very highly toxic, then the easiest and most direct kind of effect is a fatality. Can there be a death produced by a large dose or a dose of any size of the drug? Does it happen? Are there coroners' cases in which death has been shown to be very, very likely attributable to the effect of the drug?

In the case of cannabis, that is not the case. There is only one instance I know of in which death has been alleged to be due to an overdose of cannabis for which there is some chemical evidence to suggest that that may indeed be the case.

I would think that compared with alcohol, for example, barbiturates, opium, and most psychoactive drugs for which there are many, many cases of fatality, one would have to say that cannabis is not a drug with a serious risk of fatality.

Now, if one gets to other types of toxicity, things which are less immediate, which take a longer time to develop, or which develop in smaller percentages of users, then there are really four kinds of evidence that one can adduce, I suppose, in increasing order of proof. The simplest, least direct proof is the simple case report; in other words, a physician who is accustomed to practising medicine and who has experience and good clinical judgment, suddenly comes across something that he has not seen before. It is called to his attention; he looks into it and finds that the patient describes rather extensive use of the drug and he thinks, "Well, there may be a connection here."

He is curious. He looks for case reports of observations by other physicians in the literature; and if it happens more than once, if it happens a few times or a dozen times or whatever, one is alerted to a possible problem.

This does not prove causality. It simply shows that there may be something unusual happening in the people who use the drug in a certain way or a certain amount.

In going up the ladder, the next kind of evidence that is somewhat more convincing is what is often referred to as the controlled series. Once this type of chance observation has been made by a physician or an investigator, he tries to dig up more cases of this kind and then looks for matched groups.

For example, let us say he has a dozen patients or 20 patients who have some particular medical complication, whether it is a case of psychotic reaction or lung damage or whatever; he then tries to get an equal number of patients matched with respect to age, sex, socio-economic status, education, occupation, area of residence, and so forth, but suffering from other unrelated diseases, and another matched group not suffering from any disease at all.

If it then turns out that there is a higher proportion of patients suffering from this condition he is interested in who have used cannabis regularly and heavily, than there are in the other two groups, the inference is then that there is a much more clear connection between the cannabis use and the complications than simple casual observation would justify one in concluding.

It does not prove causality. It shows only an apparent association. In other words, if someone finds among a group of patients with, say, some mental aberration or some disease of the lung or nervous system or whatever, that you have a high proportion of cannabis users, compared to a similar group of healthy people or of patients with other diseases, then several explanations are possible: the heavier cannabis use among the patients could be just coincidence; or both the cannabis use and the disease could be caused by the same causal factors; or some cannabis use might be because of the disease; or the disease could be caused by cannabis use. All it tells you is that there is a connection of some kind which has to be investigated further.

Then moving up the ladder, the next kind, of investigation, which is more useful from the point of causality, is what one might call the epidemiological study. It is the reverse. Instead of looking at patients with the disease, you look at all the users you can find, a very large number of users of the drug; and you compare them with an equal number of matched people, matched in the sense that I have described before, from the general population and see among the users, does this particular complication occur with a much higher frequency than it does in the general population of non-users.

If that is the case, then you have a much better likelihood that the drug use is causally linked to the disease in question.

It still does not prove it, but it raises the level of probability; and the final . . .

May I interrupt, Dr Kalant, and ask you whether the studies, the so-called overseas studies, about which we have heard a fair amount of testimony in this case, thus far, are epidemiological studies?
No, they really do not qualify as epidemiological studies because the numbers of subjects involved are far, far too small. The numbers involved there would be fine for the kind of controlled series study I referred to before. In other words, if you have 30 patients with a particular disease that you thought was related to the use of the drug, and you have 30 matched subjects who did not have the disease, if you found a clearly significant difference between the two groups with respect to the number of regular drug users among them, that can be quite a convincing finding.

On the other hand, if you are looking for the epidemiological type, you want to say, "Is the risk of a certain disease higher in the user group than in the non-user group?" you need there, in general, thousands of subjects, not tens or twenties. The reason is that most of the serious complications that we are interested in have a very low frequency.

If I may refer to another field, to alcohol, for example, everyone will accept the connection between alcohol and cirrhosis of the liver. However, if you look at the actual frequency, it is remarkably low. It is estimated in both the United States and Canada that somewhere in the range of about 6% of all adults use enough alcohol to have problems. They are problem drinkers or clinical alcoholics.

Of these, less than a fifth develop cirrhosis of the liver. About one fifth of them develop liver disease of some kind, and less than half of these have cirrhosis. So all told, we are looking at an incidence of probably between 1% and 1½% of the drinking population ending up with cirrhosis.

If you take 30 subjects, you would have a high probability of not finding a single cirrhotic among 30 alcoholics. What you really need is hundreds or thousands of cases in order to draw conclusions about the probability of a particular type of complication, of serious complication, occurring.

Since you are on that illustration of alcohol, would this also obtain from the standpoint of brain damage in alcohol consumption?
Yes.

That is a problem that would have to be investigated for rareness of occurrence?
Yes, there are two points to be made about the examples that you bring up, brain damage and cirrhosis. Not only is there the question of the number of people who use alcohol that are likely to develop either, there is also a question of how much alcohol over how long a time.

In the case of cirrhosis, for example, the epidemiological studies indicate that you have to have an intake of at least the equivalent of 8 to 10 ounces of alcohol a day every day, not necessarily consumed every day, but average dose, over every day, for a period of probably 10 years or longer before the risk of cirrhosis becomes important. And it goes up progressively, the higher the intake and the longer the duration of the intake.

What is the average age of occurrence for cirrhosis?
It becomes important in the mid- and late 40s, 50s, and 60s. And then it begins to fall off after that.

You would not be able to detect that unless you had an investigation of sufficient duration in time for this to gestate?
Exactly. Exactly. If you look at a population of 20- to 25-year-old alcohol users, even if they were heavy alcohol users, you would not pick up cirrhosis or brain damage in that time.

Well, these studies of the second kind — you would classify the overseas studies as the second kind — you address your criticism not so much to the period of time, but more to the failure to investigate the rareness of occurrence because of the failure to observe sufficient numbers of population?
Yes.

Mr Soler: I object to the question as stated. I believe it is very leading.

The Court: No, your objection is overruled.

The Witness: No, I would say that that is exactly the substance of my criticism. But in the Jamaican study, for example, the Greek study, the Costa Rican study — they did, in fact, look at users who did use a substantial amount of the drug over quite a long period of time. The problem is entirely with the numbers of such involved.

Mr MacKinnon: You were about to explain another level of investigation, Dr Kalant.
Yes. The final level I was referring to really is the controlled experiment because from the preceding three levels, as I outlined, you can infer a connection. You can infer something about the closeness of the connection. You can infer increasing probability of the causal connection; but you can't really prove causality until you actually give the drug, produce the effect, remove the drug, and hopefully see the effect disappear.

Then you can say, if everything else has been controlled, if all other drug use is eliminated, if diet and general health, environmental circumstances, accidents, and so forth are all controlled and the drug is the only variable, then you can say that the complication which arises, that you are looking for, is caused by the drug intake.

And this, of course, is very infrequent in most drug studies. The bulk of such experiments are done on experimental animals in laboratories. You could not ethically give large enough amounts of drugs to human beings to deliberately produce the kind of damage, especially if you were dealing with something that may be irreversible. This would not be permitted. In any civilized country, it is not done.

The human studies are only short term things in which you investigate acute effects which you expect to be reversible. Therefore, in order to investigate the more serious, long lasting, or chronic effects, you really are forced to go to animal experiments. And then the question that comes up is how valid are the conclusions drawn from animal experiments with respect to the damage in the human being.

→



'You could not ethically give large enough amounts of drugs to human beings to deliberately produce . . . damage . . . In any civilized country, it is not done.'

'Chronic psychoses, mental breakdowns associated with prolonged drug use and lasting — outlasting the acute period of drug administration — this is a much less clear-cut picture.'



And I would submit that animal experiments are, on the whole, quite valid for two reasons: First of all, provided that the investigator takes due recognition of the differences between different kinds of experimental animals and humans in terms of the comparability of dosage, then you can select the dose level for the experimental animals which would be equivalent, not in absolute amount, but equivalent in effect, for a corresponding level of use in the human being.

And there are well worked-out rules of equivalence of the dosage for many, many different kinds of drugs.

And the second thing is that while most experimental animals have mental functions, for example, or in many instances physiological functions which are much simpler than those of human beings — they are analogous — in other words, the human being can do a higher order of reasoning, can do mathematics and so on — we do not have a way of testing what reasoning a rat can do; but we do know that rats can do many things in simple versions of what humans do.

They can solve problems; they can learn responses to stimuli; they can make judgments or, rather, make choices when forced to choose between alternative responses which will win them a reward or gain them a punishment, and so on. They can make in a simplified way the kind of mental activity and physical activity of the human being.

Therefore, as long as one does not attempt to extrapolate too far from the animal experiments, he can get good qualitative and fairly good quantitative comparisons that serve as predictions of the human effects. In fact, the best evidence of this is that when the Food and Drug Administration intends to license a new pharmaceutical product for therapeutic use, it requires first very extensive animal experiments, not only on the physical effects, but on the behavioral phenomena as well, in order to predict the relative safety of the drug for use by human beings before it is allowed to go to the stage of human testing.

And this is universally accepted in pharmacology, the justification for animal experiments as predicting what will happen in humans.

In leaving that, could you, for the record, summarize just by name those four aspects of finding out the effects of drugs.
Yes. The first that I mentioned, being called the case report, the clinical observation type; the second one being a controlled series clinical observation; the third being the epidemiological studies; and the fourth the controlled experimentation.

Does the evidence in respect to cannabis warrant control in your judgment of any sort?
Well, by "warrant control," you mean legal controls?

Yes.
That really is a decision which a scientist is not entitled to make as a scientist. I can offer an opinion as a citizen. But the basic judgment of that kind is a value judgment, not a scientific judgment.

Well, . . .
If I may just enlarge on that, the scientific evidence permits you to see the kind of things I have been talking about: Can drug use at certain levels, for certain lengths of time, produce harmful effects or complications of various kinds with varying predictable frequencies? Scientific observations in the form of epidemiological studies can say how many people in the population use the drug, at what level of use; correspondingly, what the risks are of such problems.

But then it is a value judgment to be made by the people, by the Congress or Parliament as the case may be, on behalf of the population as to whether the risks of widespread use outweigh the potential pleasure or benefit to be derived from the use of the drug. In our opinion, that really is not a scientific judgment; that is a value judgment.

Did you write the book which is marked as Joint Exhibit 24, by Kalant and Kalant, Drugs, Society and Personal Choice, Dr Kalant?
Yes, I am the first of two authors. The second is my wife.

I would like to refer you to pages four through six of that book.
[The witness finds the reference in question.]
The Witness: Yes.

By Mr MacKinnon: As identified there, scientific fact, probability judgment, and value judgment — is that what you are referring to in your testimony?
Yes, it is. When I referred to the area of science, I was referring to the first two, scientific fact and probability judgment. And when I referred to the role of the public at large and the elected representatives, I was referring to value judgment.

Mr MacKinnon: In the LeDain Commission, could you explain what eventually came out of the recommendations of the LeDain Commission.
Yes, the LeDain Commission did reach a final judgment on the basis of this breakdown which I have just outlined. And the Commission, which consisted of five members, came up with three divisions — a majority recommendation and two minority recommendations. The majority, consisting of three of the five members, concluded that there was adequate scientific evidence to indicate the probability of harmful effects of various kinds from cannabis use but came to a value judgment that this risk was not high enough to warrant the difficulties and potential or actual injustices which they perceived in the application of the drug control laws and the applications of criminal sanctions for the possession and use of cannabis.

And they recommended that the use of cannabis — the personal use of cannabis and the possession of it for personal use — should not be a criminal offence but should be transferred to the Food and Drug control legislation, which imposes much milder sanctions than the narcotic control legislation, under which cannabis is presently listed in Canada.

One minority report was much more impressed by the risks, the evidence concerning actual and probable and possible risks, and felt that the legislation should not be changed; that the risks were serious enough to warrant continuation of very strict sanctions against the possession and use of the drug.

And the other minority report took cognizance of the risks but felt that the infringement of civil liberties was more important and that the harm that might be done by prison sentences to young users and people found in possession of the drug — that that harm outweighed the gravity and the number and seriousness of the medical risks of use; and, therefore, recommended that possession and personal use should be entirely legal and that sale of the drug should be carried out through the Government monopoly similar to the sale of alcohol in the provinces of Canada.

Were these views and opinions — how would you classify these views and opinions from pages four to six of Exhibit 24 as scientific fact, probability judgment, or value judgment?
No, these were all value judgments. They all parted from the basis of the same scientific evidence and the same scientific probability evidence. They represented differences in value judgment as to the relative importance and the relative social gravity of the medical or social risks of cannabis use and the gravity of the harm and the social risks of the application of law.

Was there scientific data as to the relative harmfulness of cannabis submitted to the Commission before it engaged in these ultimate views and opinions?
In great detail, yes. They had their own research staff. They commissioned many research studies by investigators of universities and research institutions, and they received expert testimony from many workers in the field.

Were there disagreements as to the final voting concerning the substance or interpretation of this data?
Disagreement among . . .

. . . among the majority and the minority as to the data or the interpretation of the data?
No, I have discussed this personally with all of the members of the Commission. And, in addition to their written reports, I have their personal opinions. And all were in agreement on the validity of the scientific evidence in the sense that there was evidence of actual and potential harm. The differences lay in the area of how that was to be weighed against the harm resulting from the application of the criminal law.

Are there any current problems in the area of investigation of potential harm or effect that warrant the concern of the scientific community, Dr Kalant?
Any areas of medical . . .

Cannabis, yes.
Whether there are physical, mental, or social malfunctions resulting from cannabis?

Yes.
Yes, I would say that there are a number of areas, in some of which the evidence is, in my judgment, quite convincing; in others, suggestive; and in others, dubious but still under active investigation.

Would you be more specific.
Yes, I would say, first of all, the most clearly demonstrable beyond any shadow of doubt in my view is the acute impairment of motor performance, reaction, judgment, perception of stimuli from the environment, in other words, recognition of events happening outside one's self, in conditions in which quick judgements are needed, such things . . . as car driving and airplane piloting as an example.

There have been many, many psychological studies; there are many field observations of the intoxicated behavior under the effect of large dosages of cannabis. And in terms of the impairment of the ability to operate a car or an airplane, the dosages do not have to be terribly large. There are studies involving what are by common consent social dosages, in other words, one or two marijuana cigarettes, on the ability to operate a driving simulator or, even more impressive, to drive a car in fact.

I would refer particularly to studies of Dr Klonoff and his associates in Vancouver. These were studies carried out on the — I believe initially on the request of the LeDain Commission — but certainly reported to them at an early stage. These were highly impressive studies. There were matched or matching studies, similar ones, carried out by the research staff of the LeDain Commission itself, involving driving a car, experienced drivers operating a car on test track with problems of varying degrees of difficulty, and then the Klonoff study of actually driving a car on city streets. This was a dual control car so that the operator was there to take over in the event of potential risk through mismanagement of the car by the experimental subject. And the tests were done — many of the same subjects were tested under both conditions, on the driving track and on the city streets.

Each subject was tested with a placebo, in other words, a marijuana cigarette from which all of the active chemicals had been extracted, and then again with active marijuana at doses of either about five milligrams per kilo, which is one quite average mild marijuana cigarette, or about 8½ milligrams per kilo, which is not quite two such cigarettes.

What they found was a very clear impairment of performance which, to a large extent, depended upon the impairment of judgment as to the driver's own ability to navigate certain difficult spots in the track or on the road.

Failure to notice stop signs, failure to notice other cars or pedestrians at intersections, and so on — and this type of impairment fits very well with the other experimental studies on what is often called the driving capability, driving ability, rather than the driving itself.

The effects on such mental processes as reaction time, observation of unexpected stimuli, the ability to make rapid judgments and so on, which may be tested independently in the laboratory apart from the actual driving of a motor vehicle, which are then more meaningful because they are stressed more, they have more consequences in the driving situation. This is the first and the clearest area.

What other area did you address your focus upon?
I would say another area for which the evidence is, in my view, quite beyond question is the acute toxic reaction, acute toxic psychosis or, as some investigators prefer to call it, acute panic reaction. This is the reaction resulting from a large dose, an overdose of the drug, altering the user's perception in such a way that suddenly his or her relation with the environment is altered and unfamiliar. And this evokes feelings of alarm, panic, which may be accompanied by hallucinations, delusions, persecution.

This is a short acting, overdose effect, which almost invariably clears up as the drug leaves the body. And this has been borne out by all of the different kinds of evidence that I have referred to. There are many, many individual case reports dating from a long time back. I should point out that this type of observation was made long before cannabis was illegal because cannabis was used as a drug. It was in the pharmacopeia for a long time, from approximately the middle of the 19th Century until the 1920s.

So for nearly a century, there was lots of clinical experience with the use of cannabis as a prescribed drug. And under these circumstances, even when the drug was being given by the physician to a patient who knew that it was approved, and it was being given for a recognized purpose, and there was no legal wrangle about its use, where there was no risk of being caught and so on, despite the fact that it was under very different circumstances pertaining to then as compared to now, this type of reaction was quite identical as to its characteristics — suddenly a feeling of unreality, a feeling of distortion of perception, a feeling in many cases of being persecuted, that people were doing something to you, feelings of unreality, depersonalization, as the psychiatrists refer to it now, alarm, an acute toxic change which cleared up in almost all users within a day or so after the drug was no longer taken.

Acute psychosis in these reports that occurred many years ago — to your knowledge, that's not in this country but in other countries or . . .
Oh, yes, in this country. Oh, yes, it is reported in the medical literature of the United States, United Kingdom, France. If I recall — I don't recall a case in Germany. There certainly have been in other European countries. And this has also been verified experimentally by the administration of large dosages of cannabis to human subjects under laboratory conditions.

Over a short period of time?
Over a short period of time. These are acute reactions.

And then is there an area of concern in the non acute or chronic situation?
Chronic psychoses, mental breakdowns associated with prolonged drug use and lasting — outlasting the acute period of drug administration — this is a much less clear-cut picture.

There certainly are reports, again clinical observation type, from many, many countries; from India, the well-known Indian Hemp Drug Commission Report; from North Africa, from Brazil, from Europe and the United States as well — not only in the last century but within this decade — reports of psychotic episodes associated with heavy cannabis use.

But I think in all fairness one must say that the evidence is much less clear, because in such cases it is hard to know whether cannabis use is a symptom of mental disturbance, if the mental disturbance, in other words, preceded the drug use and caused it, or if the drug use in its turn caused mental symptoms.

I think that one would have to conclude here that the evidence is not clear-cut, but probably both things have happened. In more cases, probably a preceding mental or personality disturbance caused the heavy drug use. But there are some cases in which the observers, clinical observers, have explicitly stated that, as far as they can ascertain, the personality and the mental state before the use of the drug were apparently normal.

And in a few instances — I would refer particularly to one study by Doctors Bernhardson and Gunne in Sweden, who examined the evidence on 46 patients admitted to mental hospitals in Sweden within the last 10 or 15 years — there were psychotic reactions of considerable duration which were thought to be associated with heavy cannabis use. Most of them recovered but seven in particular recovered and then went out of the hospital and resumed the drug use, and their symptoms returned after they had resumed the drug use.

So that in this type of situation, there are perhaps better grounds for thinking that, in those patients at least, the drug use either triggered what was previously a reasonably well equilibrated or compensated mental disturbance and made it uncompensated, made it clinically overt or, in another way, caused the onset of symptoms.

All right.
Mr MacKinnon: I would like to at this time mark for identification an expert report.

The report is entitled "Report of the Indian Hemp Drugs Commission, 1893-94: A Critical Review," by Oriana Kalant.

The Court: Any relation?

The Witness: Yes, Your Honor, she is my wife. She is a scientist in her own right and is a member of the Addiction Research Foundation of Ontario.

Mr MacKinnon: I ask you to refer to pages 86 and 87. Does that further detail the question of potential psychosis from cannabis as reported in the commission at the turn of the last century?
Yes, it does. It illustrates what I would refer to as type II investigation, in other words, the comparison with the controlled series, a comparison of the frequency with which cannabis use occurs in a group of patients with certain mental symptoms compared with a controlled group of the general population.

And the conclusion based on this was — this, I should point out, is not the conclusion which the commission itself drew; it is a conclusion which the author of this study drew by analyzing the data of the Indian Hemp Drugs Commission report — that the frequency of heavy cannabis use among patients admitted to mental hospitals during the time of the operation of the Indian Hemp Drugs Commission was 7.3% compared to use among general population of only .2%.

There is a misconception which is current in North America about the use of cannabis in India. India is very often cited as a country in which cannabis use is widespread, with legal, until quite recently, socially sanctioned use and no, virtually no, harmful effects recognized.

This is rather a misconception because, though it is used very widely by the population, it is used only perhaps once or twice a year on specific religious or ceremonial occasions. Non-ceremonial use in the manner analogous to our use of alcohol or to the use of cannabis in this country for what might be called recreational purposes is extremely low in India because the use of cannabis for that purpose is viewed with a great deal of contempt and disapproval.

And this is true even to the present day except, interestingly enough, among university students in India who have acquired the habit from North American university students, who do not use it only for traditional use.

The traditional use is the drinking of cannabis in the form of a suspension in water, swallowed, under the ceremonial circumstances to which I referred, certain religious ceremonies and weddings; whereas the smoking of marijuana did not come into India until recently, except in a very small percentage, to which the report refers, in the form of ganja or charas, which is a very potent marijuana, which is . . .

The Reporter: Would you spell those terms.

The Witness: Ganja is g-a-n-j-a; charas is c-h-a-r-a-s.

These are the forms analogous to very strong marijuana and hashish respectively.

The use of these substances for more than ceremonial use, as I said, was confined to a very small percentage of the population of India. And the smoking of marijuana did not become a common thing until the past decade or two among university students and went together with dressing styles, guitars, rock folk music and so on of the North American style, which originated from North America; and, therefore, that really is an exception to the rule that I — to the statement that I made before.

In general, the Indian population does not accept the social or non-ceremonial use. Therefore, the difference between the level of use in the general population and the level of use in the psychotic patients admitted to the hospital is a very interesting finding. The caveat, which I mention in talking about this type of research as a whole — is that this does not prove that cannabis causes psychosis. It shows only that there is some kind of association between them.

Mr MacKinnon: Is this any way related to the so-called amotivational syndrome?
The so-called amotivational syndrome should more properly speaking be considered a form of toxic psychosis. That term was coined by McGlothlin and West in California some years ago to describe a picture based on clinical observations, sort of a case report type of observation that I referred to as type I.

They had revealed in many instances that the persons, particularly the students — this is common among young people but also among professionals, young adults in business and professional careers — after beginning to use cannabis, to use it regularly and heavily for some length of time, were often found to show some loss of interest in work, loss in "motivation," as that term is used in many different things, of course; but, in general, the loss of drive, the loss of enthusiasm for the kind of social productive work or activity the culture in general considers normal.

And this went together with some difficulties of memory, confusion, inability to do abstract reasoning, and to make decisions quickly and so on. They gathered together cases from the literature and gave it the title "Amotivational Syndrome." This has been the subject of a great deal of debate, particularly recently, when the term has been questioned by a number of experts within the field.

I think the debate is not really about the reality of these findings but as to whether or not they represent brain damage, because those who object to the term feel that it should not be used except in cases in which it is irreversible, even if the drug is stopped. The people who originally coined the term did not necessarily stipulate this. They referred only to certain sets of behaviors or attitudes.

And I think the reality is probably there, but more likely the toxic effects of continued high level use, continuation and gradual summation of the individual acute effects, make them more long-lasting and more exaggerated. But they probably clear up when the drug use stops. I could mention in this connection that we have our own experimental evidence to back up this kind of finding in the animal experiments, which certainly support this type of loss of motivation as a toxic effect of the drug's chronic use, which clears up when the drug is stopped.

That is investigating amotivational syndrome, not the brain?
No, I am talking about investigation of motivation in animal behavior.

In what? In rats?
Could you describe an experiment to that effect.
Yes. Yes, it was in rats. A rat can learn to press a lever in order to obtain a little pellet of food as its reward. And it can learn to do this on increasing complexity of work that has to be performed. In other words, you can make the rat press once and get a reward every time he presses; or you can train a rat to press 10 times in order to get one reward; or you can train him to press once every 30 seconds in order to get a reward; so he can learn, really, a rather large range of tasks in order to get the reward, which shows the animal's ability to perceive differences in times, differences in amounts, and distribution of work efforts and so on. It is a simple version of different kinds of tasks for human learning.

The schedule that we used, the kind of tasks that we require the animal to carry out, was to press progressively larger numbers of times for each reward. In other words, if he pressed once, he got a reward. Then he had to press four times to get a reward, then eight times, then 16 — increasing the number so that he would have to make up to five hundred or 1,000 presses to get a reward. The number of presses which the rat will make to get a reward is a measure of the rat's motivation to obtain food, because its ability to press is not impaired.

In other words, with a dose of cannabis that we used in this work, it was not impaired in its ability to press or to carry out a wide variety of motor activity.

So you look at the breaking point to see up to what point the rat will go before it stops pressing because the reward does not come often enough to make it reinforcing, or, . . . to make it worth the effort.

What we found was that with cannabis, with a dose of 10 milligrams per kilo, which sounds like a very large dose in humans, but the term — I will be happy to explain it — is not. For a rat, it is equivalent to a moderately large high, a dose which would make the animal high under the effect of the drug for probably a couple of hours or so.

Under the effect of such a dose, initially there was a sharp drop in its performance; then it became tolerant to this and when this dose was given every day, its performance rapidly came back to its normal level, and it continued to press up to the same frequency at its normal level for the first week or two. But then, with prolonged administration of the drug, its level of pressing gradually fell off, so that by the end of four weeks of daily administration, it was now pressing at about half the level. Its breaking point — is reached considerably earlier than before the drug intake.

The control group, that is, the animals not receiving the drug, getting the control solution, do not show such a falloff in performance. They continue undiminished. Then when we stopped the drug, it came back to its normal level — the rats came back to their normal level of performance within about three days or so of the end of the drug treatment. So we would consider this a loss of motivation as an effect of chronic intoxication but not an effect of permanent damage.

Were there any limitations on the study?
Limitations of what type?

Critical limitations.
Critical limitations?

Yes.
Yes, there are critical limitations on any such experimental study. For one thing, one would like to have a range of different doses because the dose we gave did produce an effect, but that experiment did not tell what a smaller dose would produce. I think that one would like to know for purpose of social judgment what is the smallest amount that could be given to produce it. In other experiments, one would like to test motivation on different kinds of performance because a motivation on a food reinforced task represents only one kind of motivation.

One would like to see the effect on motivation for avoidance of noxious stimuli of various kinds such as loud noises or other unpleasant stimuli. One would want to see the effect on motivation for other kinds of rewards. There are — I think we should say this experiment illustrates that a phenonenon occurs in relation to this particular form of motivation and this particular dosage. It shows that the class of phenomenon is a reality. It does not give us a full picture of the extent or the range of situations in which this phenomenon can occur.

Did you conduct an experiment also giving rise to what is Joint Exhibit 27, entitled "Permanent Learning Impairment After Chronic Heavy Exposure to Cannabis or Ethanol in the Rat"?
Yes, we have conducted two such experiments. The exhibit to which you refer is a report of the first experiment. The report of the second experiment is in preparation and will be submitted for publication very shortly.

This is work carried out by Doctor Khanna and Kevin Ann Fehr in my laboratory.

That is the laboratory of the university or the Addiction Research Foundation?
Both. Since I have joint appointments, our work is carried out in both laboratories; the particular requirements of the experiment dictate it.

Could you describe the methods used and the effects produced on these experiments chronically and acutely?
Yes, we had in each experiment three groups of rats. One group was a control group, which received the same handling as the drug-treated animals.

In other words, the drug-treated animals consisted of chronic marijuana extract animals which received a daily dose of marijuana extract dissolved in a very small amount of olive oil and given by stomach tube. The controls received the same amount of olive oil given by stomach tube but without any marijuana extract in it. This is to control for the possible effect of passing the stomach tube in the control rats and the varying stress or damage that the intubation would produce.

And the third group also had stomach tube passed; but instead of cannabis or marijuana extract, it got rather a large dose of alcohol. We wanted to have a comparison because alcohol has been accepted for many years to cause what is called an organic brain syndrome, that is, a syndrome of impairment of certain kinds of mental functions consequent upon varying levels of damage, permanent damage, to brain cells. And we wanted to see whether this known effect with alcohol would be matched by a dose of cannabis which produced a comparable degree of intoxication.

Therefore, we gave a dose of cannabis which was twice the dose that I referred to in the motivation experiment, 20 milligrams per kilo by stomach tube. Again, I would emphasize that in human terms this dose sounds enormous; but it allows for a difference between rats and humans in terms of their sensitivity to the drug. And the difference between administration by stomach tube and administration by smoking. It is really not an enormous dose. It is a dose which produces observable intoxication for probably about four to five hours each day.

In other words, this is a high dose. We purposely wanted to look at a high dose because in experiments of this kind, you know that small doses are not going to do any harm. And if you are doing the experiments because of the expectation that a high dose may do harm, you look purposely at the high doses. The animals were given these doses for six months,, which corresponds again to a long period of time in a human being's life. And the laboratory rats live for a life span of three years.

This represents, therefore, if the life span of a human being is an average life expectancy of 70 years or so — this represents probably something in the range of 15 years' exposure. It is deliberately a long term-high dose exposure. It should not be confused with occasional intermittent social use of small doses.

The animals were then given a couple of months without any drug in which the drug that had accumulated in their body could be eliminated. And from the known time course of elimination of the drug from the body, it would have been entirely cleared from the body at that time. So what we would look at was residual effect on the brain rather than toxic effect of the persisting drug on the brain.

During the latter part of this period, the animals began training sessions on two kinds of tasks which they had to learn. One was to learn how to solve maze problems of increasing complexity in order to earn their food rewards. The other kind of task was to learn to stay on a motor-driven belt, treadmill type of thing, which moved continuously over an electrified shock grid. And if they did not learn the task of staying on the belt, they would be pushed off the belt when they got to the end of the cage onto the grid, and they would get an electric shock to their feet, which was the motivation to learn to stay on the belt. It was an avoidance of shock.

So these represent two different kinds of learning with different skills and different parts of the nervous system involved. The learning is what we were looking at. We wanted to see how quickly they learned these tasks — the two drug groups compared to the non-drug group. And what we found was that both the chronic alcohol group and the chronic cannabis group learned significantly more slowly than the control rats.

In one of the experiments, we did a follow-up. We looked at the rats again at intervals from one month to six months after their initial learning, during which they had no tasks. They forgot the skills that they learned and we gave them an opportunity to relearn them to see whether they had remembered enough from their first learning to facilitate the relearning the second time, which is a common thing in all human and animal experiments.

This is characteristic of all learning. Once the task has been well learned and then forgotten, something carries over and it is relearned more rapidly than it was originally learned.

What we found was that again in the relearning, the cannabis and the alcohol animals performed less well than the controls.

Now, in the second experiment, we did two other things. We tested the animals, after they had had their learning trials, for mouse-killing behavior. This sounds a little peculiar maybe, but I will explain it. Laboratory rats ordinarily will not kill a mouse. If you put a mouse in the cage with a rat, it does not do anything to it. However, if you look at rats which are slow learners, which do not learn readily a variety of tasks, such rats do show mouse-killing behavior with much higher frequency.

This should not be confused with aggressiveness. I am not talking about violence or crime or aggressiveness. This is a kind of stereotyped predatory behavior. It is a built-in behavior for which a nervous pathway exists in the brain, which is ordinarily controlled by the animal for purposeful application. In other words, the animal can call on that skill for defending itself against attack



'India is very often cited as a country in which cannabis use is widespread with legal, until quite recently, socially sanctioned use and . . . virtually no harmful effects recognized. This is rather a misconception . . .'

'. . . as a scientist, I am puzzled by the obvious double standard which exists in relation to the assessment of the evidence relating to cannabis in comparison with the assessment of the evidence relating to alcohol and all other drugs.'



or for catching a prey in the wild situation. But ordinarily where there is no function served by this, it does not bring it into use.

But an animal which is a poor learner will bring it in a sort of stereotyped fashion. So you can use the mouse-killing behavior as a corollary of poor learning; and it is also shown in animals which have brain damage in the part of the brain known as the hippocampus — this is the part of the brain which a large variety of physiological psychology experiments have shown to be directly related to learning and memory. And animals with damage in the hippocampus show the same kind of mouse-killing behavior as a slow learner.

We found that our cannabis-treated rats have a much higher percentage of mouse-killing behavior than among the controls; and the alcohol-treated rats were somewhere in between. There were more, a higher percentage, of the alcohol group than the controls but not as statistically significant as in the cannabis group.

The next thing we did with these animals was to implant electrodes in the different parts of the brain, including the hippocampus and the cerebral cortex, and examine the electrical activity in these areas in the conscious waking and freely moving state.

Again, we found that the alcohol and the cannabis-treated groups, the chronic groups which had shown the poor learning and the mouse-killing behavior, also showed abnormal electrical activity in brain tracings. They showed spikes which looked like epileptic spikes in these areas.

This also is consistent with other evidence of animals in which epileptic-type activities were produced by other kinds of drug damage, that also tends to show the abnormal behavior that I mentioned. Finally, we have just recently started to look at histological sections of these brains to look for evidence of abnormality in the connections between nerve cells in this area because the number of connections between cells is a measure of the complexity of the circuitry in the brain by which the animal is able to carry out tasks of different kinds — draw on memory, draw on past experience, acquire new learning, new associations of things, and so on.

We have found that in the alcohol-treated group, there is a significant reduction in the number of such connections between the nerve cells. This has been independently found by another group in Florida.

On the other hand, in the cannabis group, we have not yet — we have not found such differences; so that we would say that the cannabis and alcohol groups are probably acting by different mechanisms even though the effects which they produce are similar.

I might mention a report which I just ran across a couple of days ago. In monkeys treated with cannabis chronically by Dr Heath's group, they report on electron microscopic examination of the brain in areas connected to the hippocampus, they claim that there are abnormalities in the junctions between those cells.

This is interesting; but I would have to say that until someone else can verify this independently, it remains simply a report and it is suggestive. I have no reason to question the technical competency of it. I can only say that such a finding should be duplicated before one has more full confidence in it.

Two or three years old or more than that — the Heath experiments — or is that another one that is recent?

No, this is a — his experiments on the electrical activity are several — were reported some time ago. But the report on the electron microscopic observations on the brains from these animals is recent. If you want me to, I can produce a copy if it would be useful to the Court.

Thank you. In your opinion, are there other areas that warrant further investigation before responsible probability decisions can be made in this area?

Yes, I would say there are two areas in which the preponderance of evidence, in my judgment, supports the idea of a high risk connection and at least two in which the connection, postulated connection, in my view, are very doubtful, in which the evidence does not warrant any assumption of clear connection.

The two that I consider to be well substantiated are the effects of cannabis on the release of certain hormones from the brain and the pituitary gland with effects on sex organs and a secondary area is lung damage. And the two which I consider to be not adequately substantiated and, therefore, of uncertain significance are the effects on the immune mechanisms, and on the nuclei of the cells, giving rise to possibility of genetic damage.

Specifically, you are saying, as to these last two areas, you think that the door could be safely closed regarding further investigations?

I would have to say that as a researcher, I feel a philosophical reluctance against ever saying the door is closed.

I think what I would say is that the evidence available does not permit the imputation of a high probability of risk in human beings, at the levels of use which are known to occur at present.

With respect to the first two areas of the last four areas that you mentioned, could you be more specific.

These are the areas of endocrine changes and of lung functions?

Yes.

Yes, indeed. In relation to endocrine changes, there was a controversy in the literature, in the medical literature, a few years back. Dr Kolodny and his group reported that cannabis use resulted in a reduction in the testosterone level, the male sex hormone level, in the blood of the user as compared to the controls. Dr Mendelson's group in Boston in a control experimental setting with administration of a quite substantial amount of cannabis, known amount, in fact, did not find any reduction.

This appeared to be, essentially, unresolved for a couple of years until two more clinical observations and a number of animal experiments, in my view, clarified the issue very substantially.

The first of the two additional clinical studies was one done by Cohen's group in collaboration with Kolodny. It was a controlled human experiment with the administration of a large known amount of cannabis over a prolonged period, I believe, of 94 days in a setting comparable to that used by Mendelson's group. And they did repeated measurements in the testosterone level weekly during the preliminary period before cannabis use was started and then over a period of many weeks of cannabis use and after and showed that there was indeed no significant fall in the testosterone level in the cannabis users for the first four weeks; but after that period, the level began to fall.

Now, these are measurements which are made in the morning after the smoking of cannabis the evening before; so that these are not acute effects of cannabis during the short periods of smoking, but effects which persist the next day and presumably represent any gradual cumulative buildup of cannabis level in the body during the regular use.

So I think this finding becomes consistent with the acute experimental finding in humans in which the administration of a single dose of cannabis lowers the testosterone level within a couple of hours after the smoking of cannabis, and then the testosterone level comes back up again within a few hours after that.

This acute effect would be gone by the next morning if you measure it after only a single dose. However, if you measure it regularly during the course of prolonged smoking and the gradual buildup of the level of cannabis in the body and therefore a gradual increase in the degree of this effect, therefore, it lasts longer into the next day.

I think this probably explains the difference between the Kolodny and the Mendelson studies. Another observation which has not yet been published in full paper but only in the discussion of another study refers to the effect of regular cannabis use in two groups of young women, two matched groups, one of cannabis users and one of non-users of the same age, same educational and other characteristics that are described in the various matchings.

And they were followed during so far — at the time of this report — for a year or two or more with periodic measurements of hormone levels, of the so-called luteinizing hormone (LH) and follicle-stimulating hormone (FSH). These are hormones released by the pituitary gland which act secondarily on the sex glands to cause them to produce the male or female sex hormone and which are also responsible for the production or the liberation of the egg cells in the female at an appropriate point in the menstrual cycle.

And what they found, that is, in the user population, the frequency of occurrence of menstrual cycles in which no ovulation took place, that is, no release of eggs took place, was increased; and other disturbances in hormone level and the menstrual function were also significantly greater in the users than in the non-user population.

The animal experiments that I referred to are by now quite a large number of experiments, at least seven or eight done in different countries in the world in different laboratories, measuring the effect of cannabis administration in rats and monkeys.

On the release of the pituitary hormone, the LH and the SH that I referred to and the release of sex hormones, the testicular or ovarian sex hormones in the blood and the measuring of various enzyme activities in the sex organs that are measurements of the degree to which they respond to stimulation by these hormones — all of these showed significant reduction at the dosage used.

In my view, what this shows is that in the animal experiments, in which larger doses are used than in the human experiments, the fact that the phenomenon can occur is clearly established. This, to me, is no surprise because, again, it is not unique for cannabis. It (this phenomenon) is produced by alcohol; it is produced by opiates, by major tranquillizers used in treating patients with mental diseases, by barbiturates — a great many psychoactive drugs can and do produce disturbances in the hormone levels which have effect on the body functions.

This is one of the risks of high dosage, whether they are for therapeutic or non-medical purposes. Therefore, to me, the surprising thing would have been if cannabis did not. I find it entirely predictable and reasonable that the animal experiments show that cannabis can and does this with high dosage. The important question is, "Do the dosages that human beings' use produce such effects?" And I think the clinical studies I've mentioned showed that at least in some human beings the use is high enough to produce such effects.

The other area, the area of lung function, here I think everyone agrees that respiratory complaints, bronchial irritation, lung irritation, is commoner among smokers of cannabis than non-smokers. This is to some extent confused by the fact that smokers of cannabis are likely to be regular users of tobacco as well.

But there are at least suggestive clinical observations to indicate that the degree of such irritation in the combined users of cannabis and tobacco is greater than in the users of tobacco alone. This, again, I do not find at all surprising because it is known that cannabis smoke has tar content just as tobacco smoke does. It is known. We have, in fact, published a work in our own laboratory on analysis of cannabis smoke; and we have found that the cannabis which we analyzed, which was ordinary, not particularly potent cannabis used in Canada, had a 50% higher tar content than one of the strongest or highest tar tobacco cigarettes on sale in Canada and several times higher than the low tar cigarettes in Canada.

So that the regular heavy user of cannabis who might smoke several cigarettes a day would, in fact, be smoking the equivalent of perhaps an additional pack of low tar cigarettes, tobacco cigarettes, today; and we know that the degree of lung irritation is proportional to the amount of tar inhaled. Therefore, it is simply like adding a rather substantial amount of extra tobacco.

I do not think there is any evidence to prove that the effect of cannabis on the lung is greater than could be accounted for in those terms, but it is significant in heavy users. There are also experimental studies to back this up and more detailed clinical investigations.

For example, washings from the bronchial tree and examination of the histological and microscopic appearances of the epithelial cells removed away from the bronchial tree in the lungs show histological cellular abnormalities. And there also have been some experimental studies on the ability of rats and other experimental animals to clear out of the lung bacteria, an aerosol spray of bacteria, which the animals inhale. And animals which inhaled cannabis smoke were able to clear the bacteria less effectively than animals which did not inhale cannabis smoke.

In your opinion, can those standards, those four standards of investigation to which you earlier testified, be applied to cannabis to the same extent that they have been applied to alcohol and other drugs?

No, I would say not as much as to alcohol, at least initially. I would say that the epidemiological studies on cannabis, not on the use, which are fairly good now — there are quite a few now on cannabis use — but the epidemiological studies on medical complications of cannabis use are nowhere near as numerous or sophisticated as the studies on alcohol.

There is a very long, well-established scientific body of evidence and discipline of investigation in the epidemiological aspects of the health hazards of alcohol and tobacco. There is very little on cannabis. I would say that in terms of the experimental studies, yes; generally speaking, many of the same people have done experiments in both areas or various drug areas including cannabis, and their scientific standards are comparable.

In terms of the clinical observations, the first step that I mentioned, yes, there are many on cannabis in terms of the matched series or controlled series step, probably fewer in relation to cannabis than in relation to alcohol and other drugs. So I would say the biggest difference is not in the amount or type of investigation, but in the use to which the information derived from it has been put.

In my opinion, as a scientist, I am puzzled by the obvious double standard which exists in relation to the assessment of the evidence for cannabis in comparison with the assessment of the evidence relating to alcohol and all other drugs.

Most good clinicians recognize the fact that the clinical observation, even though it hasn't got a control, has an inherent value in the sense that it is made by an experienced observer who knows, on the basis of his experience, what is unusual and whose observation of something unusual or unexpected occuring to a drug user is worthy of note. This has its weight.

In relation to cannabis, there is an almost total rejection by many people of clinical observations of that type. There is a rejection even of the control series type. There is very often a willingness to read into studies like the Jamaican study, the Costa Rican study, Greek study — to read into them epidemiological validity which they do not have. And I cannot account for this in scientific terms. I can only assume that the difference in the way of assessing the evidence is related to considerations other than scientific which have to do with social and philosophical arguments in relation to cannabis.

Mr MacKinnon: That concludes our examination, Your Honor.
The Court: All right.
The Court: You may inquire.

Next Month

Dr Kalant is cross-examined by lawyers representing the National Organization For The Reform of Marijuana Laws.

Crime rate declines during beer strike

By Manfred Jager

WINNIPEG — A Winnipeg RCMP official said statistics covering the first six months of this year indicate a slight decrease in criminal offences in Manitoba compared to the same six-month period of last year.

The decrease could well have something to do with Manitoba's recent strike of beer workers, the official indicated.

Sgt John Warnke of the crime prevention unit in the Manitoba and Northwestern Ontario division of the Royal Canadian Mounted Police, said: "For one thing, there is certainly a drop in the liquor offences. We're down 23.6% during the first six months this year, and the beer strike started in June. We went from 6,916 offences under the liquor act to 5,283 this year."

He said during the first three months of this year the province had 2,386 liquor offences. April, May, and June brought 3,097 offences, "which is still down from last year by 23.6%.

"From the standpoint of law enforcement we certainly had no regrets about the strike, no doubt about that."

Sgt Warnke said liquor is almost always involved in certain criminal activities. "In my experience I can recall very few cases of assault, for example, where there wasn't liquor involved, either with one party or with both."

Statistical data gathered in the northern Manitoba community of Shamattawa were encouraging because crime decreased at the same time the community opened a special facility for the detention of people under the influence of alcohol until they are sober.

Shamattawa has 530 residents, and for the past number of years has struggled with major alcohol abuse and gasoline sniffing problems, the latter particularly among children and young adults.

"In 1976 we had a high level of criminal activity, with 268 occurrences. Out of those, 38 resulted in people being detained for being intoxicated, and 26 were other Criminal Code offences," Sgt Warnke said. "They were assaults, property damage, crimes against property, weapons offences, disturbances, and so on.

"In 1977, we had 415 occurrences recorded. However, that same year we detained 294 people for intoxication because now we had a facility. By this, we prevented a lot of problems and offences. As a result, that year we only had a total of 99 criminal offences.

"During the first six months of this year, we have 82 criminal offences reported, and 128 people have been detained for intoxication. The purpose of this is to protect the people themselves, and also protect society. This seems to have worked."

Sgt Warnke said since last May the number of assaults is on a slight increase again.

"It may mean that particular month more liquor was in the community, or maybe they had some type of celebration. We only have the figures, no factual support for them."

On a province-wide basis, Sgt Warnke said, the over-all increase in criminal offences has only been 1.6%.

"During the first half of 1977, we reported and investigated 15,590 offences, an increase of 1.6% and as far as I am concerned, we are doing better than was to have been expected. The crime rate is stabilizing."

Break, enter, and theft is down by 1.5%, to 2,185 cases from last year's 2,219 cases.

Tobacco's immediate effects deter youth

TORONTO — Emphasis on immediate effects of smoking is proving more effective in deterring youth from picking up the habit than warnings about long term hazards.

That's the early finding of University of Houston psychologists studying the problem of children and smoking in conjunction with the National Heart and Blood Vessel Institute, Baylor College of Medicine, Houston. They reported on their research at the annual convention of the American Psychological Association here.

The researchers began the study aware that correct beliefs about smoking dangers were nevertheless not affecting children's behavior, whose rate of smoking has remained either the same or increased slightly over the past decade.

So they developed methods of telling students the immediate consequences of smoking — from yellow fingers and smelly breath, to test for nicotine in saliva, and showing the effects of carbon monoxide on a smoker's lungs compared to a non smoker's.

Interviews with students at various schools in the Houston area showed peer pressure was the strongest factor in teenage smoking, whatever the knowledge of the dangers of smoking.

But Richard I. Evans, University of Houston, and C. Anderson Johnson, University of Minnesota, who contributed to the APA seminar, found in separate studies that knowledge of the immediate effects helped students withstand peer pressure better than information about long term effects.

As another aid to help students decide to smoke or not to smoke, the researchers developed the film "Resisting Pressures to Smoke". Teenagers from the schools studied acted out their own ideas in the film.

The film teaches strategies such as stalling for time ("No, thanks I have to get to the next class.") and counter-pressure ("What, you want me to smoke with you? Not me. You're in the minority, man.")

The University of Houston researchers, including Richard Evans, Alice Bane, and Richard Rozelle, continue now with the final year of a two-year longitudinal study of the effects of teaching the immediate consequences of smoking on teenage smoking habits.

Compulsive gambling on increase in US

AA methods work for gamblers

By Donald G. Bastian

TORONTO — Compulsive gamblers can be restored to their families and society only if they see their problem as an addiction comparable right down the line with alcoholism.

And the most successful treatment is a combination of individual therapy focusing on the gambler's present problem and responsibility, and the self-help group approach of Gamblers Anonymous, Abe S. Kramer, clinical psychologist, Veterans Hospital, Brooklyn, New York, told the American Psychological Association annual meeting here.

GA is a strict adaptation of Alcoholics Anonymous, incorporating the pressure group approach and the warning the compulsive, or "hooked", gambler can never return safely to gambling, even in a social form.

"A compulsive gambler must hit rock bottom or in some other radical way recognize that he needs help before he can be helped — and he must realize that he can't break his habit alone," Dr Kramer said.

He added a distinctive aspect of GA is its emphasis on restitution. "The compulsive gambler arranges by budgeting his income to pay off loan companies or even loan sharks.

"Meeting obligation in payment, and making good to those harmed emotionally as well, is a therapeutic course of action for the compulsive gambler."

In contrast to alcoholism, money is the basis for the obsession of compulsive gambling, Dr Kramer said.

"It is true that alcoholics must find money to support their habit, but if they do run out of money, they always find someone to share a bottle with."

The hallmarks of compulsive gambling, according to Dr Kramer, include typically, loss of jobs and friends, hiding from creditors or loan sharks, and loss of interest in sex. Family needs are neglected, and bills are left unpaid as money is diverted into the gambler's pocket.

After a few years, compuslive gamblers often lose their families, end up behind bars as a result of extortion or robbery, or plan or even succeed in committing suicide.



Dr Kramer said a gambler's behavior may be a way of circumventing the Protestant work ethic by trying to get immediate monetary gratification for little work.

And, he said, gambling might also stem from neuroticism, an inflated or deflated self-concept, or might serve as a vicarious, symbolic outlet for violent urges.

Compulsive gambling is on the increase in the United States as gambling — race track betting, bingo, lotteries, casino gambling —is increasingly legalized, according to Dr Kramer.

The involvement of the gambler's spouse in therapy often proves successful, he said, but first the gambler must be convinced of the need for change himself. "If the individual states that he wants therapeutic help to save his job or to save his marriage his motivation is dubious.

"There should be evidence of strong conviction for change for himself," Dr Kramer said.

Alcoholics' kids skip school

HAMILTON — School attendance patterns can be an indicator of a parental alcohol problem in the same way absenteeism patterns on the job can point to an alcoholic employee, says the director of the Orillia centre of the Addiction Research Foundation.

Escape parents

Cliff Bennett told the Institute on Addiction Studies here the majority of children absent more than twice the norm and in a non-random pattern will have one or two alcoholic parents.

The child's attendance pattern may be quite different from the alcoholic worker, whose absenteeism tends to be grouped around weekends. The student may go to school at those times to escape the drinking parent who's at home.Or, if he's older, he may stay at home when the alcoholic is drinking, to protect the other parent.

In addition to high, non-random absenteeism, other signs can indicate what Mr Bennett called an "early intervention family" — a family in which the father is under 40 and the children under 10, there aren't many debts, and the spouse wants to remain, in which alcohol makes up less than one-third the calories of the drinker, he or she hasn't had previous psychiatric admissions, and there's no physical disability.

The other signs include bedwetting, poor diet, inadequate clothing, and emotional neglect. Boys are likely to act out behavioral problems, and the girls withdraw. Slipping grades, a low attention span, and attention-seeking behavior are also part of the picture.

Neglect of the children is more because of oversight than viciousness by the parents, Mr Bennett said. "They just aren't thinking. The mother and father opt out of taking care of things."

Drop outs

Heather Kilty, community consultant, St Catharines branch, ARF, said the same list of indicators, except bedwetting, had been used successfully to detect high school students who were abusing chemicals. But when their home situations became better known, it was found a high percentage of them had at least one alcoholic parent.

Mr Bennett said the Simcoe Board of Education has agreed to cooperate in early identification of these families, and the plan is to give additional training to attendance and guidance counsellors so they can work with the families.

He thought such a program would be attractive to other Ontario school boards because of their financial problems. A declining age cohort means enrolments are down, and the boards are paid on the basis of attendance. Children with high absenteeism rates mean reduced revenue, and they are also the most likely to leave school before graduation.

Mr Bennett said that Simcoe County, with a population of 250,000, ranks fourth among 54 Ontario counties and districts for suicide and mental hospital admissions. It ranks seventh in alcohol-related motor vehicle crashes, and has high rates of divorce, illegitimacy, unemployment, juvenile delinquency, and peptic ulcers.

'Clusters' of behavior help explain drug use

TORONTO — The study of drug behavior apart from the study of other "clusters" of even loosely related behavior is misguided, according to John D. Hundleby, psychologist, University of Guelph.

Only with a "natural history" of behaviors surrounding drug use will researchers be able to understand what motivates people to use drugs, he told the annual convention of the American Psychological Association here recently.

In a study of more than 2,000 children in 40 Ontario schools, Dr Hundleby found rough correlations between the use of tobacco, marijuana, and alcohol, and deliquent behavior, sexual involvement, and low academic achievement.

Dr Hundleby said this finding suggests drug use is related to lack of acculturation in some teenagers.

He told **The Journal** people are only now slowly waking up to multiple drug use, such as in the widely publicized case of Betty Ford (wife of former United States President Gerald Ford) who was treated for alcohol and Valium dependency.

He made the analogy from multiple drug use to the study of multiple behaviors surrounding drug behavior. "What good does it to do to isolate for study the use, say, of LSD, if its popularity wanes, as it largely has? But if a drug is studied in its behavioral context, then whatever its use, we have learned something significant about drug use in general."

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NZ's aid to Western Samoa: 'Death peddling'

AUCKLAND, NZ — A New Zealand aid grant of $200,000 to build a cigarette factory in Western Samoa has come under attack.

The chief surgeon at Western Samoa's National Hospital in Apia, J. Atherton, said politicians and economic planners accepted the factory, which will create 40 jobs, without considering long term health risks.

In the past year, four Samoans have travelled to New Zealand for treatment of smoking-related diseases, Dr Atherton said. "I wonder if the costs in treating these patents appeared in the calculations of the economic planners who agreed to the factory."

New Zealand's non-government overseas development agency, Corso, condemned the grant on two grounds. First, "cigarette industries, with their connotations of health risk and 'death peddling', are hardly what New Zealand's aid to the Pacific Islands should be." Second, external aid funds should not be used, in Anti-Apartheid Year, to assist the South African-based, multi-national Rothmans company.

Supporting the project, New Zealand Minister of Trade and Industry, Lance Adams-Schneider, said it was supported strongly by the Western Samoan Government, a partner with Rothmans in the venture.

Since smoking was well established in Western Samoa, it seemed reasonable to minimize the foreign exchange cost of cigarettes and to benefit from the jobs created, he said. Rothmans had also committed itself to investigate the possibility of Samoa growing its own tobacco.

Western Samoa now imports most of its cigarettes from New Zealand. The cigarettes carry New Zealand health warnings (in English). But warnings are not mandatory in Samoa and cigarette companies advertise widely without them.

The Province of British Columbia

SENIOR ADMINISTRATIVE AND RESOURCE PERSONNEL

On January 1, 1979, the most comprehensive narcotic dependency treatment program in North America will begin providing treatment to patients who have either voluntarily sought help, or who have been referred by the police or the courts. While there is a provision for a six month in-patient phase, most patients will be treated through community out-patient clinics.

Province-wide in scope, the Narcotic Treatment Program will employ a large number of people in the areas of addiction counselling, assessment and community support. In order to implement policies and guidelines of the Alcohol and Drug Commission, a number of senior administrative and resource personnel are now required.

DIRECTOR–NARCOTIC TREATMENT PROGRAM

Based in Vancouver and reporting to the Chairman of the Alcohol and Drug Commission, the Program Director will provide leadership to a province-wide organization principally located in Vancouver and the Fraser Valley, but with treatment centres in several other parts of the province. On-going responsibilities will include program evaluation and revision to meet established goals and objectives. Salary range: $27,600–$38,600 per annum.

DIRECTORS–AREA CO-ORDINATING CENTRES: Vancouver, Victoria, Nanaimo, Kelowna, Prince George

Based at the above locations and under direction of the Narcotic Treatment Program Director, the incumbents will be responsible for the regional implementation and continued operation of the treatment program. They will direct and evaluate the client assessment procedure and will provide administrative leadership to the clinical and community support personnel in the area while liaising with the communities in the area to promote program acceptance. The Director of the Vancouver Area Co-ordinating Centre will also be responsible for the planning, direction and evaluation of a number of facilities in the Fraser Valley. Salary range: Vancouver Centre, $25,200–$35,300 per annum; otherwise $21,900–$30,700 per annum.

Applicants for the above positions should have a broad administrative background in social programming, excellent organizational and interpersonal skills and, preferably, a good working knowledge of public administration. A combination of education and experience is acceptable but will preferably include a university degree relevant to the administration of social programs and several years of related experience, of which at least five has been at a senior supervisory level.

DIRECTOR–RESIDENTIAL TREATMENT CENTRE

Located on Vancouver Island at Brannan Lake, near Nanaimo, the Residential Treatment Centre will serve as both a short-term detoxification unit and a longer term physical and social rehabilitation facility for in-patients. The incumbent will be responsible for overall direction of the facility and the development, implementation and management of a comprehensive treatment program. This will include developing and implementing control measures to ensure that all patients are thoroughly and adequately assessed and assigned to an appropriate combination of treatment and rehabilitation modules.

Applicants should hold a degree in Clinical Psychology (Ph.D. preferred) and have supervised experience in a clinical setting, plus three to five years related work experience including two years in a supervisory capacity. A sound knowledge of psychometrics and psychotherapeutic techniques is also required. Salary range: $24,600–$34,000 per annum.

DRUG DEPENDENCY COUNSELLORS: Vancouver, New Westminster, Chilliwack, Kelowna, Prince George, Nanaimo, Victoria

Qualified personnel are required as counsellors at the above locations. Duties will vary and may involve evening and night work.

Applicants should have a positive attitude toward narcotic dependency rehabilitation and have a combination of relevant education and experience. Those who have participated in sophisticated addiction counselling programs will be given preference. Salary range: $18,000–$21,300 per annum.

TREATMENT DIRECTOR

Based in Vancouver and under the direction of the Narcotic Treatment Program Director, the incumbent will be responsible for the assessment and co-ordination of primary and special treatment and programming. He will advise senior treatment personnel on aspects of primary and special treatment programs and will make treatment-related recommendations to the Program Director. Salary range: $25,400–$28,600 per annum.

COMMUNITY SUPERVISION AND SUPPORT DIRECTOR

Based in Vancouver and under the direction of the Narcotic Treatment Program Director, the incumbent will be responsible for the evaluation of Community Supervision and Support programming effectiveness. He will liaise with other senior personnel in relation to co-ordinated functions and will advise community support personnel on aspects of the program, as well as making recommendations to the Program Director. Salary range: $21,300–$24,900 per annum.

Applicants for the above positions should have an intimate knowledge of the pathology, psychology and treatment of narcotic dependency. It should have been acquired through a combination of education and experience, either in the form of an undergraduate degree plus several years of experience in the practical application, such as probationary work, OR, through several years of specialized training and experience working directly with chemically dependent persons.

CLINIC CO-ORDINATORS: Vancouver, Surrey, New Westminster, Chilliwack, Kelowna, Prince George, Nanaimo, Victoria

Based at the above locations and reporting to their area Directors, the Clinic Co-ordinators will be accountable for the planning, co-ordination and evaluation of all treatments carried out in their respective clinics, as well as their day-to-day operation. Incumbents will guide counsellors on individual treatment and rehabilitation programs and will advise on difficult cases. They will participate with other Clinic Co-ordinators and the Treatment Director to assess treatments on an on-going basis, so as to develop guidelines and proposals leading toward improved treatment methods and procedures.

Applicants should hold a Masters degree in Clinical Psychology or the Social Sciences and have five years of extensive related experience, at least two of which have been at the supervisory level. Considerable knowledge of psyhometric testing and other psychodiagnostic techniques is also required. Salary range: $21,300–$24,900 per annum.

STAFF TRAINING OFFICER

Based in Vancouver and reporting to the Narcotic Treatment Program Director, the incumbent will plan, develop, organize and implement comprehensive and on-going training programs for all new and existing personnel in the Narcotic Treatment Program. He will evaluate the effectiveness of the programs and recommend changes; organize seminars and meetings; supervise preparation of training materials and co-ordinate with other senior personnel requiring the use of training resources.

Applicants should posses an M.A. in Education or the Social Sciences, together with a proven ability to develop effective training programs and several years experience in the preparation and conduct of staff training sessions. Experience in the chemical dependency or mental health fields is preferred. Salary range: $21,300–$24,900 per annum.

The foregoing positions are now open and immediately require filling. They offer challenging career opportunities, generous salaries and comprehensive employee benefits. Relocation allowances will be considered for suitable applicants. Further details may be obtained from the Alcohol and Drug Commission, phone (604) 873-0263. Otherwise, please forward a resumé containing a detailed summary of your education and past experience to the B.C. Public Service Commission, quoting competition number 78:6000-81 Location preferences, if any, should also be included. All inquiries will be acknowledged.

OTHER POSITIONS

Psychologists, physicians, nurses and assistant staff skilled in drug treatment program work will soon be required, as will be support services staff for the various clinics and the Residential Treatment Centre. A number of auxiliary positions will also exist. Applicants should watch for Public Service Commission postings and advertisements with regard to any of the above positions, so that they may acquaint themselves with the necessary qualifications, competition numbers, closing dates, etc.

Positions are open to both men and women. Obtain and return applications at address below.

Province of British Columbia Public Service Commission
544 Michigan Street, Victoria, B.C. V8V 1S3 Phone (604) 387-5303

'Scotching' the whisky

LONDON — A 120-year-old unwritten gentleman's agreement which allowed Scotch whisky distillers to avoid a certain amount of tax duty is about to be eliminated, much to the anguish of the companies.

In the past, duty-free samples of whisky which were drawn for laboratory tests for quality were later mixed with whisky on which duty had been paid and put on sale at full price.

A House of Commons committee said this amounts to some 250,000 gallons of whisky being remixed at a loss of $13.5 million in tax.

The distillers claim the practice is a backhanded way the government has helped them pay interest on loans under a unique system of taxation for whisky makers.

The distillers have to pay the government the full duty on their product before it is even shipped out to wholesalers and retailers. This means each year some $800 million is paid out before any money can come back from customers.

To cover this payment, the industry borrows money at commercial rates and has to pay the current rates of interest. In contrast, cigarette manufacturers and brewers are allowed a period of grace by the Treasury before duty payments are made.

In 1977, the distillers exported 94 million imperial gallons of whisky, and earned some $5 billion in foreign currency.

Aussies and Rx abuse

SYDNEY — An Australian Parliamentary Committee is investigating the abuse of over-the-counter and prescription drugs.

Senator Peter Baume, chairman of the Senate Standing Committee on Social Welfare said: "Therapeutic agents are causing increasing concern among professional health workers and others who are aware of the need for care in the use of drugs available over the counter or on prescription.

"Much statistical and research information is available. The committee believes that it should collate and examine this information in conjunction with the views of those who understand the significance of what is happening in the use of such medication and who are concerned," Senator Baume added.

The inquiry will cover known abuses, and the incidence of problems arising from the use of medication. In addition, it will examine the extent and appropriateness of use of therapeutic agents and trends in that use.

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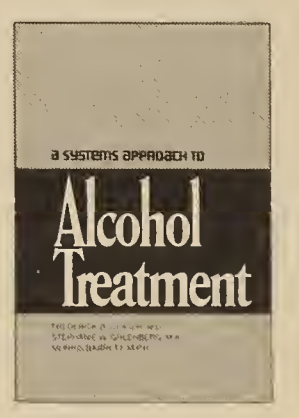


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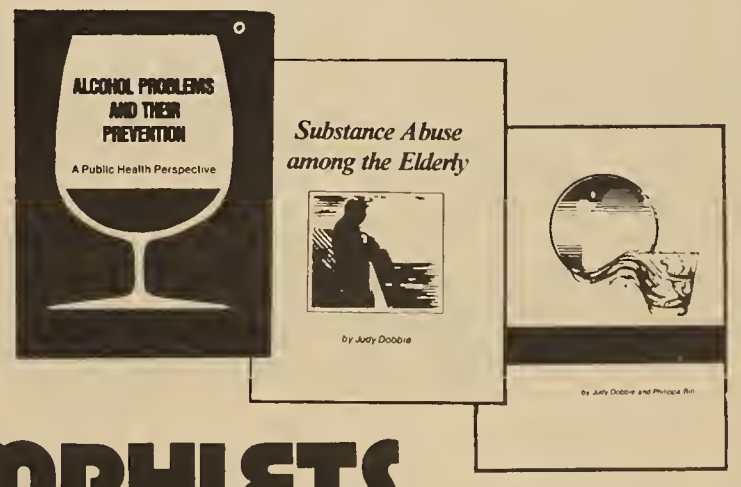
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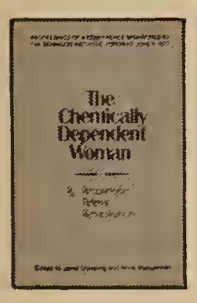


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by RON HALL

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(Grune and Stratton Inc, 111 Fifth Ave, New York, NY, 10003. 1978. 516p. $26.50)

Other Books

Young Alcoholics — Alibrandi, T. Compcare Publications, Minneapolis, 1970. Part 1: the reasons for the growing popularity of alcohol among youth, theories, myths, facts, tips for the parents. Part 2: drinking patterns among youth in Orange County, 1976 survey, recommendations questionnaires, tables, bibliography, appendix. 219p. $5.50.

Alcoholism In Aruba — Wever, O. R. Drukkerij Van Denderen B.V., Groningen, 1977. Descriptive epidemiology, analytical epidemiology, operational research, therapeutic regimes and results. Bibliography, appendix. 308 p.

The Client/Agency Monitoring System Of The Alcohol And Drug Commission Of British Columbia — Hollander, J. J. Alcohol and Drug Commission of British Columbia, Vancouver, 1977. Development, implementation, methodology, data processing, findings, costs. 143p.

The Alcohol And Drug Commission of British Columbia Accountability System For Funded Agencies — Hollander, M. J. (Jt). Alcohol and Drug Commission of British Columbia.

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Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six point scale. For further information, contact Linda Chung, coordinator of the group at (416) 595-6150.

My Name Is David, And I'm An Alcoholic

Subject Heading: Employee assistance program, alcohol and alcoholism overview, alcohol and the family, treatment, rehabilitation.
Details: 23½ minutes, 16 mm, color, sound.
Synopsis: As David jogs around the neighborhood he recalls how his supervisor at work threatened to fire him unless he upgrades his work performance. After a confrontation with a counsellor, it becomes apparent that David's drinking has been the main problem. David tries Alcoholics Anonymous, and his wife goes to Alanon. David is not willing to admit being an alcoholic and continues to drink, but agrees to enter an inpatient rehabilitation centre. There he's advised to use Antabuse, and develops other interests. Davis is welcomed back to work, and his family is much happier with him sober.
General Evaluation: Fair to good (3.6). A contemporary, informative and interesting film with a clear message and high technical quality. However, therapeutic approaches of the employee assistance program counsellor depicted in the film were questionable.
Recommended Use: with the presence of a resource person, the film may be beneficial to audiences of 15 years of age and older.

Beating The Booze Blues

Subject Heading: Youth and alcohol.
Details: 25 minutes, 16 mm, color, sound.
Synopsis: High school students with TV personality Lawrence-Hilton Jacobs present a series of skits, songs, and experiments involving the use of alcohol. An experiment shows that at a 0.05 blood alcohol level, subjects are slower at opening a combination lock than they were prior to drinking. A young ex-alcoholic talks about his experiences with alcohol and the reasons why he quit. Students state various reasons why they drink — including to be accepted, and to forget problems. Finally, a doctor explains how alcohol affects the body.
General Evaluation: Good (4.3). A contemporary, interesting, and informative film, it was deemed an effective teaching aid.

Recommended Use: Likely to benefit general audiences of 12 to 18 years of age.

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6. Some definitions and parameters of addictions *by R. Gordon Bell*
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Canada

Detox Training Program — Oct 16-20, Nov 27-Dec 1, 1978, Toronto, Ontario Information: Mr G. Gooding. Assistant to the Coordinator, Detox and Rehab Programs, Addiction Research Foundation, 33 Russell St, Toronto, Ont, M5S 2S1.

The College Of Family Physicians Of Canada (Ontario chapter) Annual Meeting — Oct 16-18, 1978, Toronto, Ont. Information: Marcia Barrett, 4000 Leslie St, Willowdale, Ont, M2K 2R9.

Canadian Psychiatric Association Annual Meeting — Oct 18-20, 1978, Halifax, Nova Scotia. Information: Dr A. Cote, secretary, Canadian Psychiatric Association, Suite 103, 225 Lisgar St, Ottawa, Ontario, K2P 0C6.

United States

The Treatment And Rehabilitation Of The Alcoholic — Oct 1-6, 1978, Savannah, Georgia. Information: Dr Bernard M. McGahee, 12506 Cranwood Lane, Savannah, Ga, 31406.

American Association For Automotive Medicine — Oct 3-6, 1978, Louisville, Kentucky. Information: AAAM executive-secretary, PO Box 222, Morton Grove, Illinois, 60053.

Association of Labor-Management Administrators And Consultants on Alcoholism Annual Meeting — Oct 4-6, 1978, San Francisco, California. Information: ALMACA, Suite 907, 1800 North Kent St, Arlington, Virginia, 22209.

Substance Abuse Is More Than An Addiction — Oct 11-12, 1978, Cincinnati, Ohio. Information: Ann Blankenhorn, Alcoholism Consultant, 532 Maxwell Ave, Cincinnati, Ohio, 45219.

4th Annual Symposium On The Detection Of Drugs In Biological Fluids — Oct 13-15, 1978, Baltimore, Maryland. Information: Myron E. Shiplet, 640 Frederick Rd, Baltimore, Md, 21228.

Youth, Alcohol, And Social Policy Conference — Oct 19-20, 1978, Arlington, Virginia. Information: Gail Dickerson, Program Director, Health Education Foundation, 600 New Hampshire Ave NW, Washington, DC, 20037.

National Conference On Medical Education In Alcohol And Drug Abuse — Nov 16-17, 1978, Washington, DC. Information: Dr Charles Buchwald, Conference Coordinator, Career Teacher Center, Downstate Medical Center, 450 Clarkson Ave, Box 32, Brooklyn, New York, 11203.

New York State Association For Human Services — Nov 20-21, 1978, New York City. Information: Family Service Association of America, 44 East 23rd St, New York, NY, 10010.

3rd Southeastern Conference On Alcohol And Drug Addiction — Nov 29-Dec 3, 1978, Atlanta, Georgia. Information: Conway Hunter Jr, Medical Director, Addictive Disease Unit, Peachford Hospital, 2151 Peachford Rd, Atlanta, Ga.

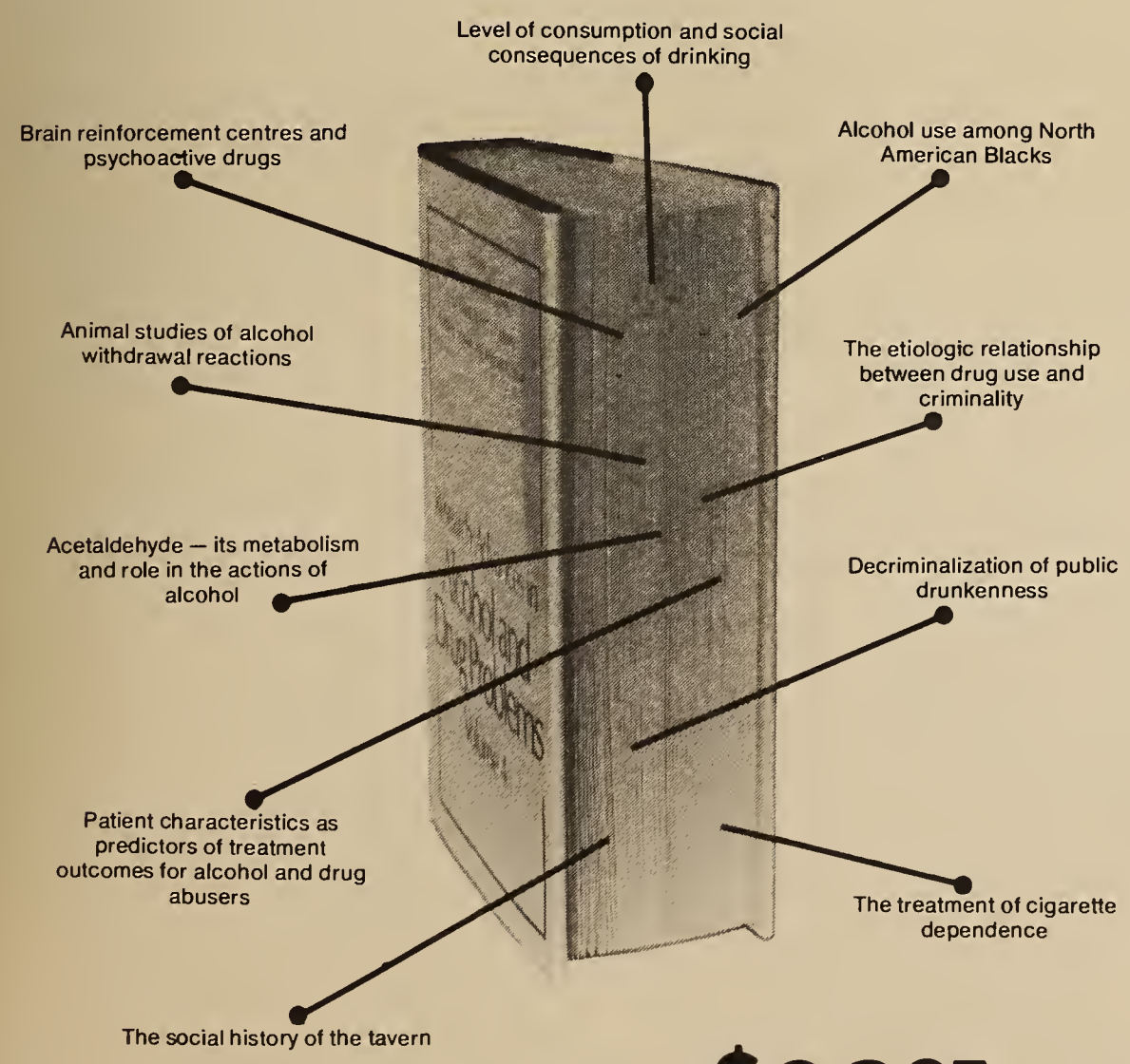
National Organization For The Reform Of Marijuana Laws 7th Annual Conference — Dec 1-3, 1978, Washington, DC. Information: NORML, 2317 M St NW, Washington, DC, 20037.

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International Symposium On Alcoholism And Drug Dependence — Oct 16-20, 1978, Sao Paulo, Brazil. Information: International Council on Alcohol and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

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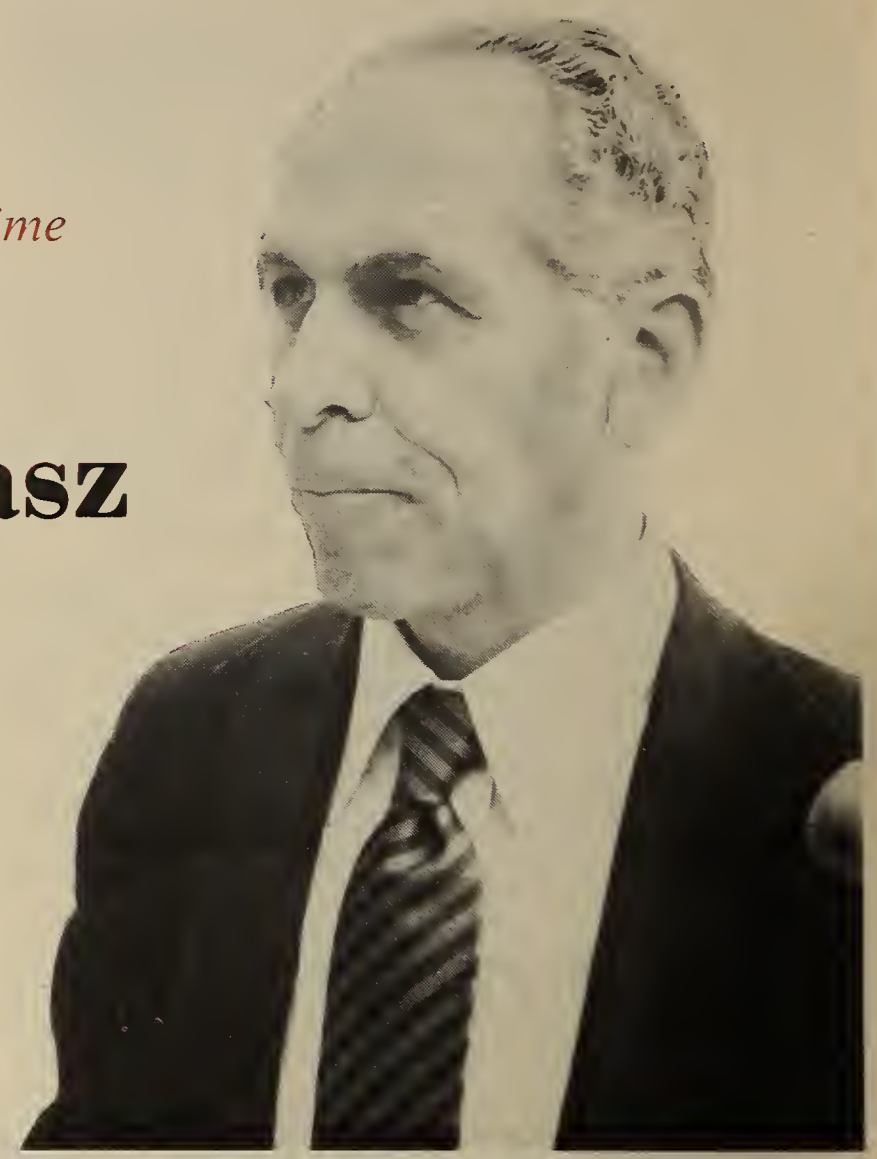
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'Drugs do not cause crime any more than religion causes crime . . . Crime is being manufactured by drug prohibition . . .'

Interview with Szasz



Thomas Szasz is a professor of psychiatry and a psychoanalyst at New York University, Syracuse. He is well known for his radical views about his profession and what he calls the lies of mental illness.

Dr Szasz neither condones nor encourages the use of non-medical drugs. His own addictions extend little beyond the necessity for orange juice at breakfast. He doesn't use narcotics, or nicotine for that matter, and finds he has a take-it-or-leave-it attitude to alcohol.

However, he maintains people who do use drugs are unjustly and irrationally persecuted if those drugs are not considered "legal" by society. He suggests they should all be legalized to remove them from the black market and surrounding crimes. It would then become a moral decision resting upon individuals whether to use them or not — and it would be up to the individual to be responsible for the consequences.

Recently, Dr Szasz was in Vancouver addressing a symposium on the compulsory treatment of heroin addicts, a bill now enacted by the British Columbia government and due to be enforced next year.

In the following interview with medical writer John Braddock for **The Journal,** *he refers to the BC program and explains why he thinks people should not meddle in the lives of others.*

Can you see the need to prohibit any sort of drug?
No. In my opinion people should be left to their own devices as to what they take. They should be able to take anything they want. If they poison themselves that should be their problem — just as people are now allowed to do with cigarettes or alcohol or food.

Food?
Of course. Eating too much is very dangerous, especially for males. They get fat and get heart attacks. So, according to the medical-political logic that asserts that certain drugs are dangerous and should therefore be prohibited, eating too much should also be prohibited.

Now you're being fatuous. Eating too much doesn't really cause such distress as, say, the taking of heroin. Nor is there crime involved.
Drugs do not cause crime any more than religion causes crime, or television causes crime. If people kill or steal, they are criminals, regardless of whether or not they are on drugs. Drug-related crimes are now so common because drugs are prohibited. Crime is now being manufactured by drug prohibition just as it was in the 1920s by (alcohol) prohibition in the United States.

So you think there should be no regulations at all regarding any drug?
Drugs should not be prohibited. Crimes should be. And they should be punished.

Such as?
Such as a drunk driver killing somebody. In the United States, such a person often goes Scot free. But such an act should be punished severely. It's a crime — not drinking, but killing someone. Drugs are no more relevant to this issue than religion. Suppose a person kills somebody because, he says, God told him to? Should you excuse that? It doesn't matter who told him, he's not supposed to kill anyone, whether God told him or demons told him, whether he wants drugs or money. We have to come back to first principles: we should punish illegal acts, and should ignore idiotic excuses for them.

Just to shrug your shoulders and say someone's addicted to heroin is that person's problem, is a pretty callous attitude. A form of I'm-alright-Jack.
From all I've read you don't get addicted to heroin the first time you try it. Or the second. So the problem's easily solved: don't get addicted in the first place. Or, if you do, take the consequences.

Do you think there might be physiological reasons why some people become more addicted than others?
I know the view, but I don't believe it. When there will be evidence for it, then I'll accept it. People used to believe Jews couldn't become alcoholics. Nobody believes that nonsense anymore.

Actually, when we speak of heroin "addict" we're talking nonsense. There are no heroin addicts. There are only people who take heroin. Some people take coffee and some people take aspirin. There are all kinds of things you can put into your body. If you put it in often and like it, you may be called an addict. I think the term is misleading.

If addiction doesn't exist in this sense, what is it?
It is a habit. Habits are good or bad depending upon whether the person judging them likes them or not.

Obviously we have switched our habits. A hundred years ago there was no such thing as "addiction" as we now talk about it. People took whatever they wanted. But then people were not supposed to engage in various sexual activities. You were not supposed to have sex with people other than your wife, and even with your wife only in certain positions. Now you can buy all the pornography you want and engage in all the sex you want. Today it's drugs that are bad for you.

So, if you look at it historically, sex prohibition and drug prohibition have simply changed places. Incidentally, now that we're talking about history, what do you think are the origins of Western prejudice against opiates?

Their strong effects?
No. One of the main reasons for the anti-opiate prejudice is that they are foreign drugs — as against alcohol and tobacco which are domestic drugs. Alcohol has got to be a good drug: it is used in both the Jewish and Christian religious ceremonies. Even during Prohibition priests received a special dispensation to use it. Doctors made millions selling it by prescription. In short, one of the historical reasons is that opiates are "Oriental" drugs. What have we got against Orientals? That should be perfectly obvious.

We've all heard that if you take opiates you go kaput, you become a useless, miserable, hooked creature — no good to anybody or yourself. Right? This is one of the mammoth psychiatric mendacities that's been spread about for decades.

What happened in America is that the Chinese in the west built the railroads faster and cheaper than the whites. The Chinese are hard workers and are smart — on or off opium. But a politician can't say, in 1978: "I hate the Chinese." The contemporary political style is to hate the abstraction, and get at the people indirectly. You're supposed to hate homosexuality, then you can get at homosexuals. You're supposed to hate opiates, then you can get at "heroin addicts." Actually, there's a whole list of things called controlled substances — which is another lie. There are no controlled substances, only controlled people.

So you disagree with the concept that heroin use is a disease, as it's worded in the BC law?
Of course I do. It's nonsense. It's another lie. You might as well call using alcohol or tobacco a disease. Sometimes people will say: "Well, isn't it true it will cause a disease?"

But in fact, opiates are singularly safe, which is an interesting point. Fifty thousand deaths a year on US highways are directly attributable to alcohol. Once again, that many deaths are due to smoking. Compared to these immense medically-proved dangers, the use of heroin, morphine, and so on is quite negligible.

Which, of course, is one reason to be against it. I'm serious. If you're being persecuted, the worst thing that can happen to you is to be innocent. If you're guilty, then the authorities can pity you. If you're innocent, then they'll get really mad. They'll want to eradicate you. This is one of the reasons people are so fanatically opposed to opiates — because they are so "innocent."

But to get back to calling heroin use or alcohol use a disease: This is a very stupid idea because if acts that cause diseases are themselves diseases, then there's no end to what is a disease. You'd certainly put high on the list such things as boxing, which I nominate for a disease called *pugilism*. Surely, boxing damages the brain more than taking heroin. I'd also nominate skydiving and hang-gliding. How many people die swimming every summer? How many fall off mountains? I looked into this once; on an average summer, in just three or four months, more than a thousand people fall to their deaths in the Swiss, French, and Italian Alps. How many die taking drugs? Certainly less than that.

So the idea that doing X is a disease because it causes injury is simply a big lie. That's not the definition of disease. The definition of disease is a pathophysiological abnormality of your body. How you get that disease is irrelevant.

What are your views on the treatment of heroin habit?
To call getting someone off heroin a "treatment" seems to me absolutely idiotic. Getting people off heroin is no different than getting somebody off anything else you don't like. How about getting somebody off overeating, or masturbation, or stealing, or Marxism? I insist that if there is no disease, there can be no treatment.

Okay. But some habits can lead to more danger than others. How do you think children should be warned against the heroin habit?
In a very low key. My model would be the way people are educated about highway traffic or high voltage cables. After all, people don't go around throwing steel wires over high voltage lines to play with. They do it only to commit suicide. Everybody knows high voltage lines are very dangerous, but there are no huge government programs educating people against them.

So how do people quit the habit if they want to?
Just like people do now with cigarettes or food. They quit. Period.

And where do those who are weak get the willpower?
From the same place you get the willpower to meet any of life's other challenges.

Yes, but some techniques must be better than others?
The answer to this is probably better given in the autobiography of Malcolm X (the Black Muslim leader who was assassinated) than anywhere else. He was a heroin dealer and taker and he says it's a habit you have to break. And he said of all the habits he knew, and of all the people with drug habits he knew, the cigarette habit was the hardest to break. Anyway, how did he give it up? He became convinced there was only one problem in the world. He knew what evil was — white men. So he became a Black Muslim. That, in my opinion, is the classic cure. You become a fanatic. After all, who was a famous man free of drug addiction? Who didn't even eat meat? Adolph Hitler. He didn't drink. He didn't smoke. He was a vegetarian.

So the answer is to go for the health cult?
There's an old saying that no one is as intoxicated as a man high on abstinence. So long as most people believe that self-disciplined self-medication is evil and that coercive meddling in other people's lives is good, and so long as opportunistic politicians eagerly exploit that mass-belief — well, so long as that is the case, it's quite pointless to take seriously attempts to deal with or "control" the so-called drug problem.

THE BACK PAGE

Deviance and Drug
PERIODICALS READING ROOM
Humanities & Social Sciences

'Incestuous' relationships hurt drug workers

SEATTLE — Staff in alcohol and drug abuse treatment agencies must fulfill their professional, social, and sexual needs on the outside or they become prone to the "incestuous" relationships which injure staff and programs.

William White, of the National Training System, Des Plaines, Illinois, thinks its because most staff members do attempt to meet their needs within organizations that there is such a high (20%) annual "burn out" and staff turnover.

He told the Alcohol and Drug Problems Association conference here he has worked in the past several years in a variety of professional roles and has become "painfully familiar with the seemingly high casualty rate" among staff.

Mr White said the "organizational family" of most agencies operates with "incestuous dynamics" in which "a significant number of staff meet most, if not all, of their personal, professional, social, and sexual needs within the boundaries of the staff group."

There is little professional contact with outside sources, and most of the staff are similar in age, background, values, and ways of living. There is no outside stimulation, the programs are isolated from both client and community, and staff members

By Harvey McConnell

who do not support treatment ideology are excluded.

Most of the social needs away from the program are met by other staff. "This can take the form of staff members getting together away from work, but continuing to focus all of their energy and conversation on work issues," Mr White said.

Sexual relationships between staff members can "drastically alter the working of the group, reduce both the quality and quantity of services provided to clients, and not uncommonly lead to the painful extrusion of members from the group."

Mr White said it could be that the types of people drawn to the work create the problems.

He said it is not uncommon to find people "who come to the field not to provide intimate relations as a service called treatment, but to find and experience intimate relationships themselves.

"Many persons, whether career therapists or career 'patients', have found it is only in the emotional intensity of dealing with extreme and tragic problems that they experience intimacy and feeling. Many may have had difficulties experiencing and maintaining personal intimacy away from the profession, particularly in relationships which are sexual."

Sexual relationships between staff can lead to rumor and gossip, and break the staff into a number of cliques.

More from ADPA

Pages 2, 3, 4.

Vol. 7 No. 11 2nd Class Mail Reg No. 2776 **TORONTO November 1, 1978**

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The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

Canadians easing up on pot laws

By Anne MacLennan

TORONTO — Canadians are more liberal in their attitudes to marijuana than has ever been suspected, and probably more liberal than their United States neighbors.

Response to a question on marijuana in the September Gallup Omnibus — a cross-country survey — revealed that 46% of Canadians feel either that possession of small amounts of marijuana should not be a crime or that, like alcohol, marijuana should be sold in government stores.

Thirteen per cent feel possession should be a crime but that offenders should be subject to fines only. Selling should be subject to the full range of criminal penalties.

Only 31% of Canadians are content with the status quo, i.e. possession and selling should both be crimes and offenders should be subject to the full range of penalties, including arrest, fines, imprisonment, and criminal records.

Eric Single, a scientist in social studies at the Addiction Research Foundation (ARF) told **The Journal:** "The exact question has never been asked before but the response to similar questions (in the past) would indicate there has been a liberalization of public attitudes."

As for the nearly 50% favoring some form of decriminalization, 22% said possession for personal use should not be a crime although possession of larger amounts, and selling, should be crimes. Twenty-four per cent said marijuana should be sold in government-licensed stores with the government setting standards of purity.

The question's inclusion in the Gallup poll was commissioned by the Statistical Information Unit of the ARF.

Pot in political limbo?

Page 2.

A similar question was included in an April, 1977 Gallup Poll. Asked whether possession of small amounts of marijuana should be a criminal offence, an offence subject only to a fine, or not be an offence at all, only 23% felt possession of small amounts of marijuana should not be a criminal offence.

"The results of the poll this year would indicate this number has doubled," said Dr Single.

The results also suggest Canadians may be more liberal on the marijuana issue than people in the United States although, again, the questions were not identical and true comparison is difficult.

However, a 1977 US study showed that only 11% of people beyond 26 years of age, and 35% of young adults, from 18 to 25 years, favored some form of decriminalization of marijuana as the "ideal" situation.

The study was a National Survey on Drug Abuse by the US National Institute on Drug Abuse.

Dr Single noted that the four-part question in the September poll in Canada covered all options available to the government — possession, like selling, should be a crime subject to the full range of penalties; possession should be a crime but offenders subject to fines only; possession of small amounts for personal use should not be a crime but possession of larger amounts should be a crime subject to the full range of penalties; and, like alcohol, marijuana should be sold in government stores. In all but the fourth option, selling would be a crime subject to the full range of penalties.

"I would think the results of this poll are going to be a strong impetus to decriminalization," said Dr Single.

"All three parties have come out in favor of decriminalization at various times and I suspect they've been waiting for some public feeling. So, the poll is very timely."

Timely yes. But it remains to be seen whether the attitudes will be translated into political action. As a pre-election issue, cannabis has remained in limbo.



Afghan tribesman

Afghanistan's new revolutionary, Soviet-oriented rulers are to cooperate with the United Nations in a program intended to reduce the illicit flow of Middle East heroin sold in European black markets. Afghans like the tribesman in above picture are intended to benefit from the policy which involves income substitution and compensation. Page 11.

Pot smokers in majority

Ottawa fattens user file

By Bryne Carruthers

OTTAWA — Another 30,695 Canadians now have the distinction of having their names added to the still-secret files of the federal bureau of dangerous drugs on "known" cannabis users in Canada.

As might be expected, about a third of the latest additions to the drug files were people between 20 and 24 years of age.

However, the distinction (if that's what it can be called) is dwindling rapidly: the addition of the 30,695 new names in 1977 brings the total number of known cannabis users recorded by the federal bureau of dangerous drugs since 1968 to 191,591 — roughly one of every 115 Canadians.

Most of the names added in 1977 resulted from police reports associated with the 37,812 convictions for cannabis crimes also recorded by the bureau in 1977.

For comparison, in 1976 there

(See — Pot — page 2)

Inside The Journal

Alcoholism in new pope's homeland
The Back Page

A scientist in court: Part II
Page 7

Pot still bears the brunt of drug crime enforcement

(from page 1)

were 33,281 cannabis convictions, indicating that police are still concentrating heavily on cannabis crime enforcement, despite the promise six years ago of federal amendments to the Criminal Code on cannabis crimes. (See story below).

In fact, cannabis convictions made up 96.2% of the 39,293 drug convictions recorded in 1977, with phencyclidine, heroin, and cocaine crimes running a distant second, third, and fourth (615 convictions, 375, and 336 convictions respectively).

Meanwhile, the bureau added the names of 17,242 known users of narcotic drugs (mostly heroin, PCP, and cocaine) to its secret files in 1977, compared to 15,264 in 1976.

The new total of known users of illicit drug users is 96,107.

The number of known users of illicit hallucinogenic drugs, such as LSD, MDA, psilocybin, STP, and mescaline, now totals 22,185 in Canada, according to the bureau's files.

Last year, 1,117 new names were added, still far below highs of 3,630 and 3,143 added in 1974 and 1971 respectively.

At present, the bureau of dangerous drugs keeps its files on known and suspected drug users (some of whom have never been actually convicted of a drug crime) secret, even to the extent of not admitting that a file is being kept on any individual.

A federal cabinet order has been drafted by Federal Health Minister Monique Begin, proposing to allow named individuals to see parts of their individual files under the privacy provisions of the Human Rights Act.

However, the cabinet order, which the health minister had promised would be approved more than a month ago has, reportedly, encountered resistance from at least one other federal cabinet minister.

Federal, provincial, and municipal police forces, which supply much of the information contained in the drug files, have complained about opening the files to public scrutiny.

During 1977, Ontario led the provinces in drug convictions with 14,333 of the 39,293 recorded; Alberta was second with 7,347; followed by British Columbia with 5,920; and Quebec with 4,019.

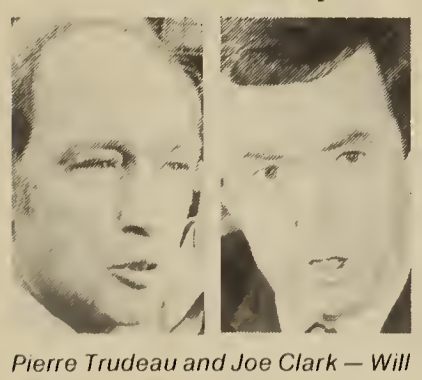
Among the 30,695 new known cannabis users added to the files in 1977, nine were under 11 years of age, 2,105 were 16 or younger, and 65 were 50 or older.

Will cannabis take the stage in pre-election theatrics?

By Bryne Carruthers

OTTAWA — With Canada's Parliament now facing several months of pre-election theatrics until the federal spring election, the cannabis issue seems nowhere in sight and unlikely to emerge for at least another year, if then.

The problem, it would seem from this Ottawa vantage point, is that in the public's mind, cannabis is no longer a burning issue, despite the fact tens of thousands of mostly-young Canadians are convicted of cannabis crimes each year and gain a criminal record in the process



Pierre Trudeau and Joe Clark — Will they bring cannabis out of political closet?

(See — Ottawa — page 1).

In addition, some politicians in the ruling Liberal government, at least, fear that easing up on cannabis penalties remains a "no-win" situation.

Take, for example, Prime Minister Pierre Trudeau's emotional outburst at a news conference dominated by questions about the possibility of a referendum on hanging.

The Prime Minister, evidently frustrated by the growing disenchantment in the public mind over his government's action or inaction, blurted out that perhaps he should start throwing hot potatoes back at Canadians, via a referendum, and then letting them live with the consequences.

He referred specifically to three issues: abortion, capital punishment, and marijuana.

The Trudeau government promised six years ago to transfer cannabis (marijuana and hashish) from the Narcotic Control Act to the less-stringent Food and Drug Act, and to have only fines as the penalty for first-offence possession cases.

This promise, still awaiting some sign of surfacing since one bill passed by the Senate and never glimpsed by the Commons disappeared in a morass of unfinished Parliamentary business several years ago, followed the recommendations of the LeDain Commission on Drugs (whose other recommendations also have disappeared from sight).

In this last stretch to the election wire, cannabis so far hasn't appeared as an issue in pre-election rumblings, even though it did surface in an earlier bout of election pains when both Trudeau and Opposition Leader Joe Clark indicated they favored easing up on cannabis (**The Journal**, April).

All indications are that it will only come out of hiding if members of the Canadian public push, and push hard.

Until then, the politicians will continue to study the idea to death, in the fond hope of discovering a palatable way to offer a change without losing any votes.

ADPA, NDAC clash

WASHINGTON — The 1979 annual meeting of the Alcohol and Drug Problems Association of North America will be held here August 26 to 30, the same week as the National Drug Abuse Conference scheduled for New Orleans.

Augustus Hewlett, ADPA executive director, said the dates "are the only ones available in Washington during the two-month period which would satisfy the requirements for the ADPA.

"It is unfortunate the dates are the same as those for the NDAC in New Orleans, but we had no alternative. We have no intention whatsoever of competing with the NDAC."

The ADPA was scheduled originally to gather in New Orleans at a co-located meeting with the NDAC. However, the furor surrounding the New Orleans meeting, (The Journal, October), prompted the ADPA to withdraw.

Meanwhile, a number of those who resigned as co-chairpersons of the NDAC are planning to hold a national drug conference in Washington on the same dates as the ADPA.

Controlled drinking: It's still an option

SEATTLE — Controlled drinking or drug-taking should be considered an option for abusers who first make some fundamental changes in their lives, according to Jerome Carroll, PhD, of Eagleville, Pennsylvania.

Dr Carroll said controlled use should be considered "because the vast majority of substance abusers will not practise total and permanent abstinence. At least, they will not abstain from all previously abused substances, especially after completing their initial in-patient, intensive treatment program."

Dr Carroll, director of psychological services, Eagleville Hospital and Rehabilitation Center, added that "most substance abusers will attempt controlled use anyway, regardless of all the efforts staff make to dissuade them from doing otherwise."

Examples of controlled use would be alcoholics who attempt to resume drinking without abusing alcohol; alcoholics who avoid alcohol altogether but who use marijuana without any evidence of abuse; and heroin addicts who drink alcohol and smoke marijuana without abusing either substance.

Dr Carroll told **The Journal** he started considering the question of controlled use some three years ago at Eagleville when several former heroin addicts were not able to attend an award ceremony because they had been seen having a social drink.

Although Eagleville still practises the principle of total abstinence for patients, a committee has been set up to consider controlled use.

Dr Carroll said: "When you approach the abstinence issue you have to look across the whole series of categories of substances of abuse and to make tough decisions about which ones present physiological and psychological danger to the person and which may not be so dangerous."

He does not advocate the field abandon total and permanent abstinence as the preferred treatment objective for the majority of long term substance abusers.

"I do believe, however, it is time the substance abuse field acknowledges that some substance abusers, after being treated, are able to lead sober and self-fulfilling lives while drinking and/or using drugs in a non-abusive manner," he added.

The fear of making a "slip" is always with those who try and practise total and permanent abstinence. When a person "falls" he is overcome with despair and will often be too embarrassed to return to a treatment facility.

Dr Carroll said there are limits. "Attempting controlled use of a substance on which the addiction was centered without abusing that substance, is a very risky business. To the best of my knowledge, most substance abusers have not been able to manage this."

Hank sure knew how to take care of his body

By Wayne Howell



Hank lit a cigarette and inhaled deeply. He had driven a hard bargain and he was feeling satisfied.

"She's a real beauty," said the salesman, "and I know you're going to be very happy with it."

"I hope so," Hank said, still smarting at the purchase price and thinking how long the car would have to last before he could afford another one.

"You take care of it," said the salesman, "and that baby'll last you a lifetime."

A day later, Hank was stretched out in his Lazy-Boy watching The Game on the tube with his friend Al.

"You know," said Al, "you really otta do something about your body."

"I guess you're right," said Hank, loosening his belt, a belt that was straining against the better part of a 12-pac and five slices of pizza.

"Undercoating is what you need," said Al. "I was you I'd get one of them Z-bart jobs. An ounce of prevention is worth a pound of rusty rocker panels."

Hank agreed. After all, he had to protect his investment. And so the next day he shelled out $225 for an Envirogarde Treatment. It was expensive but it was worth it for as Al had said — you only got one body and the only thing between you and the wrecker's hammer is preventive maintenance.

A few weeks later Hank met Al for lunch.

"You know," said Al over cocktails, "a lot of guys think you can protect your body with undercoating; they don't stop an' think the salt can rust 'er out from the outside as well as the inside. I was you I'd protect 'er with one of them Ming jobs: Ming Mirror Finish, Vitalizing, or Perma-Shine."

"You got a point," said Hank, popping a buttered roll into his mouth. And so the next day he spent $100 to get his car Tuff-Koted. The car's acrylic skin glowed with an inner vitality and Hank was so proud of his car that he would take it down to the corner store to get chips and pretzels for The Game even though the store was within walking distance.

A few months later Hank was hoisting a few with Al at their favorite pub. "You know," said Al through the smoky haze, "a lot of guys spend money on their body but they neglect the power train; it's the heart and guts that are important."

"Couldn't agree more," said Hank, "and that's why I run 'er through all them fancy tests at the Esso Diagnostic Clinic every time I take 'er in for my routine maintenance. Sure it's expensive — those fancy compression tests and everything — but the way I look at it, you gotta catch things goin' wrong early, right?"

"Right," said Al.

It was about one month later that Hank noticed the car hesitated slightly when he stepped on the accelerator. He didn't think much of it but he mentioned it to Al one Sunday afternoon when Al was over watching The Game.

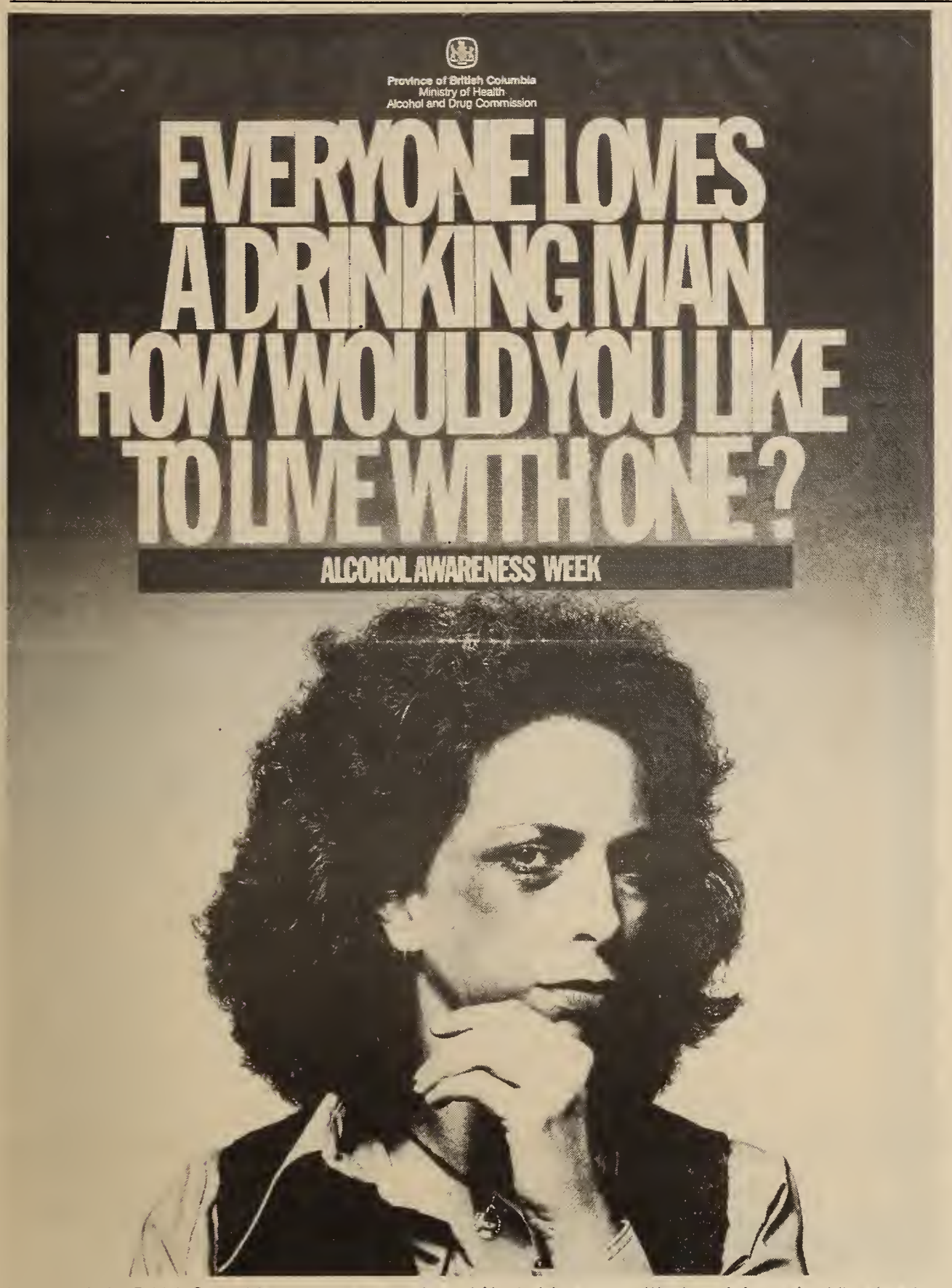
"You drive a high compression car like that 'round town all the time and before long she gets all carbonned up; her valves start sticking. What you gotta do is take 'er out on the highway and open 'er up every now and then; that's the key to long engine life," said Al.

"Good point," said Hank, and from then on he took the car out once a week and let it cruise at high rpms for a minimum of five miles. Some days it was raining or snowing or there was A Game on the tube and Hank really didn't feel like making the effort — but he did because he knew it was important and he knew it would pay off. It did too.

"You know," said Hank's wife, "how well he maintained that car."

"I know," said Al, "and I really am interested. Very interested. But look, this heart attack thing has really got me shook up. How he'll come around after the funeral? Then maybe we can work a deal."

(Wayne Howell is an Ottawa physician and freelance writer.)



Last month the British Columbia government conducted Alcohol Awareness Week, an information blitz aimed at reducing Canada's alcoholism rate — right in their own province.

BC alcoholism highest in Canada

By John Braddock

VICTORIA — Provincial Health Minister Bob McClelland says British Columbians "have the worst record of alcohol abuse in Canada," and he's determined to do something to correct the problem.

He told a news conference about 10% of the BC population has a drinking problem and the numbers are increasing.

"Perhaps it is significant that we also have the worst driving accident record in Canada, and the two are probably connected," he said.

Mr McClelland added there's an estimated 237,000 people in the province who are hazardous drinkers. By this he meant they are already experiencing ill health or are in danger of doing so because of their drinking.

He said of these, 113,000 are definite alcoholics.

The health minister said the provincial Alcohol and Drug Commission will start a series of programs to make drinkers more aware of the problems. And the number of alcohol treatment agencies will be expanded.

He estimated $200 million will be lost this year by BC industry because of lost productivity, absenteeism, and accidents due to alcohol.

Mr McClelland said his ministry would also provide $140,000 for the Interior Native Alcohol Abuse Society to start a 24-bed intensive residential treatment centre near Vernon for native Indians.

The federal Indian Affairs department will also provide additional funds.

Next month:
'Worst region'
in North America

Parents 'nonchalant' about pot

SEATTLE — American parents must be disabused of nonchalant attitudes to their children's use of marijuana.

Lee Dogoloff, director of The White House drug policy staff said "the 'only marijuana' concept must be changed, and this is our challenge for the future."

The American government's thrust against heroin has unfortunately been misinterpreted by the public.

Mr Dogoloff said: "While we have concentrated — and justifiably so — on addicting drug abuse, we may have inadvertently given the impression that other kinds of drug use were not important, or had no consequence.

"And for young people, this is just not true." Mr Dogoloff said daily use of two drugs, marijuana and alcohol, are the most troubling: more than 9% of high school students report daily use of marijuana and more than 6% daily use of alcohol.

The goal with young people should be to discourage all drug use including alcohol, marijuana, and tobacco.

Many parents have fallen into the trap that "heroin is serious, but marijuana isn't."

Mr Dogoloff said he had had parents "tell me that they were brushed off by drug abuse experts when they expressed fears over a child's marijuana use."

The change in attitudes to cigarette smoking demonstrates what society can do.

Mr Dogoloff: "The atmosphere surrounding cigarette smoking has radically altered, with more and more people disapproving of it, more non-smokers defending their rights, and more pressure against those who smoke."

Mr Dogoloff said the signal should go out to parents and communities as to their powers and roles. "Parents must be made aware of the facts and reassured of their legitimate grounds and bases for intervention.

"Our challenge is to reverse the rising trend of toleration to drug use in our society."

Marijuana option tests continue

By Carl Edgar Law

CHICAGO — Proponents of marijuana as a therapeutic agent may have suffered a small setback with the development of an anti-glaucoma drug, tested with encouraging results at University of Chicago.

The synthetic compound, nabilone, developed by Eli Lilly, resembles tetrahydrocannabinol molecularly but Frank W. Newell says it does not produce marijuana's undesired effects.

The professor and chairman of opthalmology at Chicago says there was no euphoria, dry mouth, lowered blood pressure, increased pulse rate, or pupil dilation in tests.

But intraocular pressure dropped 10% to 54% (average 34%) in 16 patients studied.

Dr Newell says that doesn't adequately portray the drug's effectiveness since maximum reduction occurs in patients with high intraocular pressure.

Many patients in the study had low pressure at the beginning of the test because they had received topical glaucoma medication until 36 hours before nabilone.

An oral dose of from 1 mg to 2 mg of the benzopyran compound took effect within two hours and kept pressure down for about six hours.

The average pretest pressures were 32 mm Hg (right eye) and 33 mm Hg (left). These dropped post-test to 19.3 and 19.06, respectively.

Thomas J. Zimmerman, an associate professor of opthalmology and pharmacology at Louisiana State University in New Orleans, believes the Chicago group may be approaching the goal that has been sought since the early 1970s. It was known then that marijuana reduced intraocular pressure — but researchers wanted to get rid of what "makes people high," Dr Zimmerman said.

It is not yet known whether tolerance develops. The drug's effectiveness did, however, decrease when it was used topically for a week in rabbits.

Nabilone may challenge marijuana on another therapeutic front as well. Paul Stark, a research associate at University of Chicago (and synthesizer of the drug) says it is being prepared for FDA clearance for Phase Three IND testing as an antiemetic in cancer patients — another putative use for tetrahydrocannabinol.

Give addicts new aids to get unhooked: Powell

CALGARY — Addicted people should be encouraged to view themselves and the world around them in new ways to become "unhooked", according to Arnold Powell, senior research associate, Centre for Advanced Study in Theoretical Psychology, Edmonton.

Dr Powell, and Dr Joseph Royce told the 13th annual conference of the Canadian Addications Foundation "(Addicted people) should be encouraged to employ new ways of finding out information about the world around them," to explore alternative values, and to learn to accept themselves.

However, Dr Powell said a given therapy or technique may be helpful to one person, but not another. Behavior modification may be one answer, but treatment techniques such as Gestalt therapy, or an Alcoholics Anonymous approach, are valuable to other people.

"It should be recognized there are a great many ways in which individuals can make significant changes in their lives, and there is probably a unique way for each individual," Dr Powell said.

He said professionals in the drug dependence field should evolve rehabilitation systems flexible enough to accommodate different clients.

Pot case could go to top

OSHAWA — A provincial court judge's decision, which could eventually alter the criminal status of marijuana, is due to be handed down this month, following a lengthy trial in which the defence is challenging the classification of the drug as a narcotic.

Edmond Brown, a Toronto lawyer and member of the National Organization for the Reform of Marijuana Laws (NORML), has based his case on grounds that marijuana was arbitrarily placed in the schedules of the Narcotic Control Act without sufficient evidence that it is a narcotic (**The Journal**, Mar, Aug).

His client, Michael R. Taylor, also a member of NORML, was charged Oct 1, 1977, with possession of marijuana.

Michael D. Willinsky, a University of Toronto pharmacologist, testified for the defence. Mr Willinsky has acted as a consultant to the LeDain Commission of Inquiry into the Non-Medical Use of Drugs and as a consultant on marijuana at the Schering Institute in West Berlin.

Mr Willinsky claimed marijuana is not considered an opiate-narcotic drug by pharmacological, medical, and scientific standards, but rather a sedative-hypnotic.

Mr Brown has suggested the case could eventually end up in the Supreme Court of Canada.

Protein snacks posing problems

TORONTO — High protein snack foods served at parties, which help slow down absorption of alcohol into the bloodstream, are acceptable for moderate drinkers, but could pose a possible danger to heavy drinkers.

This is suggested by research at the Addiction Research Foundation of Ontario's Clinical Institute by Hector Orrego and colleagues.

Dr Orrego said experiments with rats showed high protein doses increase the oxygen demand in the liver. For a heavy drinker with a liver problem this could prove serious, producing hypoxia and possible necrosis (destruction of cells) in the liver.

Dr Orrego added, however, that there appears to be no danger to the moderate drinker who consumes high protein foods such as cheese, nuts, and meat at parties.

Heads sought for US drug institutes



Ernest Noble (left) and Loran Archer.

WASHINGTON — Nine candidates are now being considered for the position of permanent director of the National Institute on Alcohol Abuse and Alcoholism in the United States.

The list includes Loran Acher, who has been acting director since the departure of Ernest Noble (**The Journal**, June).

Another list of candidates is being considered for a similar position as head of the US National Institute on Drug Abuse. Karst Besterman, who has been acting director of NIDA since the resignation of Robert DuPont, is among those on the list (**The Journal**, August).

The final decisions will be made by Gerald Klerman, director of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA).

Some of the priorities Dr Klerman will consider in making his final decision will be satisfying minority and special interest groups, and the medical profession.

Half a million problem drinkers left in lurch in UK

LONDON — The British Government has now been informed officially that more than half a million problem drinkers in England and Wales are not getting the help they need.

Confirmation that services are not matching demand comes from the Advisory Committee on Alcoholism established in 1975. The report, published by the department of health and social security,* is regarded as a "blueprint for future services."

It says statutory health and personal social services in England and Wales (Scotland is considered separately) have not responded adequately to the problem.

Too much reliance had been placed on specialist statutory services including the 25 Alcoholism Treatment Units in England and Wales which were "patchily distributed ... poorly coordinated, and unable to cope."

At the same time, many doctors and nurses who came into contact with drinkers failed to deal with them properly because of inadequate training and support. Many problem drinkers, therefore, remained unidentified, receiving treatment only for the illnesses which resulted from the excessive drinking.

The committee calls for:

1. A comprehensive pattern of services providing help for ALL problem drinkers and bringing together statutory and voluntary agencies;
2. Earlier recognition of problem drinkers by family physicians, social workers, community nurses, and health visitors;
3. Planning by health and social service authorities to include recognition of the needs of drinkers;
4. Recognition of the special needs of the homeless problem drinker.

The committee further argues the cost of better services for problem drinkers could be widely offset by the consequent reduction in the number of problems associated with alcohol with which social workers and doctors currently have to deal.

But it recognizes that if problem drinking grows and is given due priority, the increased cost could not be fully met from existing resources.

***The Pattern and Range of Services for Problem Drinkers — Report of the Advisory Committee on Alcoholism; Department of Health and Social Security, Alexander Fleming House, Elephant and Castle, London SE1 6BY.**

A message to my patients

Unfortunately, I find that the excessive use of alcohol is a problem with some of my patients — and is growing, particularly amongst women patients.

Alcohol abuse by itself is a hazard to health, but when combined with the abuse of tranquillizers, sleeping pills, anti-depressants and other drugs, can lead to serious consequences.

The first step in controlling alcohol abuse is self awareness.

I therefore urge any of my patients who are concerned about their drinking, or the drinking of those close to them, to discuss the problem with me.

Accept
Western Hospital
Seagrave Road London SW6
Telephone 01-381 3155

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ACCEPT: Promoting self-awareness on alcohol problems.

Young alcoholics are homeless too

LONDON — Young people with alcohol problems are increasingly found to be homeless too, an inner city survey has shown.

"For insecure, bewildered young men and women, homelessness presents a major problem. Very often treatment for alcohol dependence can begin only after some form of abode can be found," it warns.

This is a major conclusion of ACCEPT*, The Alcoholism Community Centre for Education Prevention and Treatment, based at Western Hospital in Seagrave Road, south-west London.

ACCEPT has been obliged to establish what it describes as its "No Fixed Abode" service which gives top priority to finding accommodation for clients.

"We consider a 'roof over one's head' as merely a first step in a long term comprehensive program designed to assist people in learning how to live effectively and comfortably in a complex nuclear society — a society some youngsters look upon as a frightening, treacherous, urban jungle," the report says.

Working in conjunction with a group known as the Cyrenians, ACCEPT offers shared flats to clients where they take responsibility for cooking, cleaning, and general administration.

But the accent on NFA referrals merely reflects the growing national trend towards young, alcohol-dependent clients, the agency goes on. Statistics collected in 1976 and 1977 show a 70% increase in under 25s requiring help over the 12-month period.

The inner city pattern now, therefore, shows nearly a quarter of referrals as aged 30 or under and more than a half aged 40 or under.

Meanwhile, at the other end of the scale, there has also been a sharp increase in alcohol dependence problems in the age 60 and over age group. This might be "a harbinger of the American experience wherein alcoholism among the retired ... has reached serious proportions."

The ACCEPT report concludes many more minds should be concentrating on the development of realistic and comprehensive programs of primary and secondary prevention with, initially, the provision of adequate resources to educate the educators.

***ACCEPT 2nd Annual Report Western Hospital, Seagrave Road, London SW6 (Tel 01-381-3155)**

Test detects trouble before cirrhosis

CHICAGO — A method that detects liver damage in alcoholics prior to the development of cirrhosis has been developed by chemists at Abbott Laboratories in North Chicago.

The test is based on elevation of the substance cholyglycine in the blood serum of people with damage to the liver.

Cholyglycine is one of the bile acids, which have been suggested as indicators of liver disease, chemist Stephen Weiss, PhD told **The Journal**.

Dr Weiss recently reported the first study to find cholyglycine a useful indicator of liver damage. The main advantage of the new test is that it gives fewer positives than other tests in current use, indicating that the test is more specific.

Dr Weiss, and coworkers Phillip Miller and Martha Cornell, evaluated the cholyglycine test in populations of normal volunteers, patients with no liver disease, and individuals with alcoholic liver disease.

The individuals with alcoholic liver disease had both mild and advanced cases, and some also had cirrhosis.

In testing 144 serum samples from the alcoholic liver disease case, they found that the cholyglycine level was elevated in 97%. In every case of mild alcoholic liver disease there was a high level of cholyglycine. None of the other tests they studied showed this consistency.

NIDA part of WHO

WASHINGTON — The National Institute on Drug Abuse in the United States has been formally designated a World Health Organization Collaborating Centre for Research and Training on drug dependence.

It joins the Addiction Research Foundation of Ontario, and the Centro Mexico de Estudios en Salud Mental of Mexico, which have been designated previously as such centres by the WHO.

A number of speakers from ARF and CMESM reported on various problems of drug dependence at a two-day seminar which marked the NIDA designation by the WHO.

ADPA News Briefs

. . .Seattle

Ministers should learn something about gerontology and pharmacology so they can help older members of their congregations who have problems with drugs and alcohol. The pastor has a moral right to intervene in problem areas as a friend and counsellor, according to Rev Karl Schneider, director of education at the Eagleville Pennsylvania Hospital and Rehabilitation Centre.

He said older people are less visible as a problem, and need help in becoming less accepting of drugs, which they use often to make up for feelings of powerlessnes.

• • •

Particular alcoholic clients are being matched with particular counsellors in Little Rock Arkansas after their reactions are assessed from a series of black and white photographs containing 16 combinations of race, sex, body build, and attire.

Randall Cox of the University of Arkansas at Little Rock, said a study using photographs provided valuable insights to counsellors in relation to their initial impressions on alcoholic clients. It was found "the counsellors' race, sex, body build, and attire influenced significantly the alcoholic clients' initial expectation of treatment success."

• • •

Techniques must be devised to help heroin addicts look at their pasts and profit in future. In most cases addicts are more interested in pleasing a parole board than in being helped, according to John Hand, clinical psychologist with the Michigan corrections department.

Mr Hand said the large drug sub-culture in prisons puts pressure on addicts to resist any therapy or involvement with society. His department has devised techniques to help addicts to help themselves.

• • •

Cocaine use is spreading rapidly in western Europe, and phencyclidine (PCP) has also started to appear in a number of cities over the past year, according to Peter Schioler, chief consultant to the Danish Ministry of Education on alcohol and narcotic problems.

It is believed PCP is being smuggled in through the United States and Canada and so far no illegal laboratories for manufacturing the drug have been discovered. Officials in Denmark consider PCP to be the most dangerous drug of abuse yet introduced, Mr Schioler said.

HOLIDAYS AHEAD...

When the party's over
leave the driving to a pro

332-6329



Why is Santa driving?

Friends don't let friends drive home drunk. That's the message the Tarrant Council on Alcoholism and Drug Abuse in Fort Worth, Texas, is spreading for the holiday season ahead. For the third year in a row, the council has promoted the campaign which provides a free ride home service for party goers on New Year's Eve. The campaign logo (above) gives the telephone number. The campaign involves also a package of responsible guidelines for hosts, and radio, newspaper, and television publicity aimed at keeping the drunk driver off the road. The "free ride home" service is staffed by volunteers from local community agencies, and clubs.

Montreal's heroin addict population is rising

By Dorothy Trainor

MONTREAL — The heroin addict population here has increased markedly. This and other developments are included in a recent report by two members of the Montreal Urban Community's (MUC) Police Drug Squad.

There are now 2,500 known heroin addicts in the MUC area with each spending an average $80 a day to support their habit, or $72.5 million a year, says the report prepared by Constables Gerald Caron and Jean Champagne.

In the past, Montreal has been considered a fairly stable and non-critical area relative to heroin addiction. Previous estimates of the numbers of addicts have ranged from 1,000 to 1,500.

Statistics from the report of the MUC constables, which was based on information obtained from drug pushers, arrested drug users, the RCMP, and the Quebec Police Force, were published in *The Gazette*, a Montreal daily newspaper. The report, *The Gazette* notes, attributes 60% of all major crime in the MUC to drug users who must finance their habits at a cost of more than $2m per day.

Other revelations in the report were:

• The MUC recorded 22 murders last year linked to drugs, and a battle to control the profitable market;

• There are an estimated 6,000 regular cocaine users in the MUC, spending an average of $240 each a week for a total of $5.76m a month;

• There are an estimated 10,000 part time cocaine users who spend $120 a month for a total of $1.2m per month. Combined with the cost to the regular users, this gives a total cost for cocaine in the MUC of nearly $7m monthly or $84m per year;

• There are an estimated 100,000 regular marijuana users, and an additional 50,000 weekend users.



The streets of Montreal: Sixty per cent of all major crimes in the inner city are drug related, a Montreal police report says. The number of known heroin addicts in the city has climbed to 2,500.

"I've been telling people for the last three years that the Montreal heroin problem is going to increase," John Devlin, executive director of The Portage Program for Drug Dependencies told **The Journal.**

"Personally, I know of four heroin drug overdose deaths in the past six months. Constables Caron and Champagne also noted four heroin drug overdose deaths in their report. When I meet with them, I'll find out if they were the same four. I am also wondering if these deaths have to do with impurities of the substance, or ignorance on the part of users."

Portage at Lac Echo is operating at full capacity, Mr Devlin added. There are 70 clients in treatment, with four to five requests for admission daily.

Asked if he considered the estimate of 2,500 heroin addicts correct, Mr Devlin said: "When the estimate was 1,500 MUC heroin addicts, we had about 10 to 15 of them in treatment. Portage now has 25. Perhaps that is coincidental, but the ratio remains at 1% of the estimated population.

"I can only speculate about escalation — if in fact an escalation is taking place — but law enforcement agencies have shifted their attention to importation and major drug trafficking as opposed to keeping the pressure on the street. This may be a possible explanation."

Peter Vamos, Portage psychologist said: "The Ministry of Social Affairs in Quebec does not have an individual singularly responsible for drug abuse and dealing with toxicology. Pathetic. And Quebec is not isolated. It probably does more than some of the other provinces. There seems to be a tendency to downplay drug problems in Canada, to give the illusion that all is well, that the 60s are over, and everything is under control.

"It is a frustrating thing to be told by bureaucrats that there is no drug problem in their provinces, and all one has to do is pick up the daily paper to find out there are drug problems. It is just that the spectacular phase of drug abuse is over, but this does not permit us to sweep present abuses under the rug."

Accessibility of health info 'chilling'

By Carl Edgar Law

OTTAWA — The Canadian Health Records Association (CHRA) has produced a code of practice to provide stronger safeguards for confidential health information.



***Dennis Timbrell:** The media know the power of information.*

Executive director of the organization of 3,000 health record administrators and other personnel said the code was in its final stages when the Ontario government ordered its Royal Commission of Inquiry into the Confidentiality of Health Records in Ontario (The Honorable Mr Justice Horace Krever).

The code is basically a statement of principles meant to guide all personnel who have access to medical information.

While no one suggested the code was the final answer to the problem, Ontario Health Minister Dennis Timbrell said it "goes a long way toward resolving the problems posed by the collection and storage of medical information."

Addressing a CHRA meeting here he said the only people who don't seem to care about medical confidentiality are the public.

He and other speakers noted that public meetings to discuss the problem aren't much of a drawing card.

In the United States the problem is similar. Last year the chairman of the US Privacy Protection Commission noted that 350 witnesses who appeared before him largely echoed that they had nothing to hide and didn't care what information people obtained on them.

But, said Mr Timbrell, "the government is concerned. The medical professionals are concerned. The media are being attentive, I think, because they recognize the enormous power of information."

But Dr James H. Brown said: "Put quite simply, people cannot go to doctors without revealing to them things they do not want divulged to others," whether it be sexual impotence, psychiatric matters, medications, or anything else which might embarrass or compromise an individual socially, or in terms of employment."

Meanwhile, Mr Timbrell said the cost of storing data in pre-computer days ensured that files were regularly destroyed and that finding information in current files was like, "finding a needle in a haystack.

"Today, there is no problem finding the needle.

"It is technologically possible today to make everything ever recorded about a person, completely accessible in less than one second."

A chilling note was added when it was noted that Canadian insurance companies store their medical information on insurance applicants, not in Canada, but in the Medical Information Bureau, in Massachusetts.

This bureau holds files on 11 million North Americans and the information is available to the 700 member companies — though not to the applicant.

The standard life insurance application form, with individual variations, includes questions on drug and alcohol use as well as questions pertinent to any psychiatric history.

EDITOR
Anne MacLennan

STAFF WRITER/PRODUCTION EDITOR
Karin Pargas

CONTRIBUTING EDITORS
Harvey McConnell (Washington)
John Shaughnessy (Toronto)

SCIENCE EDITOR
Dr Ruth Segal

The Journal

Published by Addiction Research Foundation of Ontario
33 Russell St. Toronto. (416) 595-6053

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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Letters to the Editor

Cocaine question

I would like to express my surprise at a statement which appears in **The Journal** (April) in the article entitled In Perspective: Cocaine, by Oriana Kalant. It runs as follows: "Common wisdom to the contrary, psychological rather than physical dependence is the essence of addiction."

I had no idea this conclusion had been reached so definitively by anyone involved in research, and I would like to ask Dr Kalant to explain her reasons for being so categorical about a matter which I am sure many people, including some respectable scientists, still consider controversial.

Lise Anglin
Research Planning
Addiction Research Foundation
Toronto

Psychology root of addictions

In her letter to the editor, Lise Anglin expresses surprise at my "categorical" statement: "Common wisdom to the contrary, psychological rather than physical dependence is the essence of addiction" (**The Journal** — In Perspective: Cocaine, April, 1978).

Her surprise stems from her belief that this issue remains largely unresolved and therefore subject to disagreement. To the best of my knowledge, this problem is not overtly controversial, it is simply that scientists from different disciplines use the word "dependence" to refer to different things.

For behavioral scientists, the essential question is the psychological factors that cause and maintain drug-taking behavior. For molecular pharmacologists, the main focus of interest is the tissue (ie, physical) changes that result from drug taking.

I am not aware that the public at large, including many workers in the drug field, are engaged in any debate about this matter. The notion is nearly universal that physical dependence on drugs — the prototypical example being heroin — is the most dreaded consequence of drug use. Among the lay public, however, psychological dependence is characteristically perceived as a far less serious problem. In my view, this is both scientifically erroneous and harmful to society because it leads to a false understanding of the comparative seriousness of dependence on various types of drugs.

My reasons for believing that the essence of addiction is psychological rather than physical, which I feel are quite compelling, are as follows:

(1) Compulsive drug-taking, even in the presence of severe adverse effects, occurs with both depressant (eg alcohol, opiates, barbiturates) and stimulant (eg amphetamines, cocaine) drugs. Since most experts in the field believe physical dependence develops with continued use of the former, but not of the latter, then the only common denominator is the compulsive drug-taking behavior that we refer to at present as "psychological dependence". The intensity of this behavior, at least in experimental animals, is as great, or greater, with stimulants such as cocaine than with depressants such as alcohol or morphine. I should add that I, as opposed to many drug experts, believe there is good evidence to show that stimulant drugs also produce physical dependence. But I do not feel that *it* is the major determinant of prolonged use of these drugs.

(2) Long after the withdrawal of depressants, when there are no longer any detectable clinical signs of what is called the withdrawal syndrome, many if not the majority of patients easily relapse into drug-taking behavior when not under medical or other supervision. It can not, therefore, be said that the painful physical symptoms of drug withdrawal are the primary reason for reverting to drug taking.

(3) People who have become physically dependent on depressant drugs for medical reasons (eg administration of morphine for the management of severe pain) experience the same physical withdrawal syndrome as people who self-administer the drug. Yet, most of the former group do not experience any craving or desire to continue taking the drug. They just want to get rid of the symptoms. Obviously, this means that the presence of physical dependence (as revealed by the withdrawal syndrome) does not of itself lead to drug taking.

(4) Finally, it is self-evident that compulsive repetitive drug taking precedes rather than follows the development of physical dependence. Therefore, the latter can not be invoked as the primary cause.

A well informed open debate on this important problem should eventually clarify the present state of public misunderstanding. Ms Anglin's letter is a welcome contribution to this aim.

Oriana J. Kalant, PhD
Scientist
Addiction Research Foundation of Ontario
Toronto



'And you have the right to make an obscene phone call to your PM.'

A watery toast

I want to compliment you on your full-page coverage of India's five-year Prohibition Plan aided by our WCTU membership in that country (**The Journal**, September). You will be pleased to know when President and Mrs Carter gave a banquet in The White House for the President of India, the customary toast to a visiting dignitary was offered in water only.

Marian B. S. Crymes
Washington Correspondent
National WCTU-BUR Legislation
Washington, DC

Exceptional

May I congratulate you on the extremely interesting report Harold Kalant: Scientist in Court (**The Journal**, October).

I always find **The Journal** interesting and informative but this issue is exceptional.

D. J. Stewart
Professor of Hospital Pharmacy
Faculty of Pharmacy
University of Toronto

Impressive

The staff at the National Council on Alcoholism — Alaska Region — enjoy reading our monthly issue of **The Journal**. Interesting and informative articles coupled with excellent layout and artwork present an impressive, professional newspaper.

Madeline Enbanks
Public Information Director
National Council on Alcoholism
Alaska Region
Anchorage

The Journal welcomes Letters to the Editor. Letters bearing the full name and address of sender may be sent to: The Journal, 33 Russell Street, Toronto, Ontario, M5S 2S1.

The Journal

Published by Addiction Research Foundation of Ontario

Vol 7, No 11 TORONTO, November 1, 1978

Harold Kalant: Scientist in the courtroom -- Part II

This concludes a two-part series excerpted from transcripts of testimony at United States government hearings on a suit brought by the National Organization for the Reform of Marijuana Laws (NORML) challenging the constitutionality of US laws on marijuana.

Dr Harold Kalant, director of biological studies at the Addiction Research Foundation of Ontario was one of several expert scientific witnesses called to testify. Last month **The Journal** *presented direct examination of Dr Kalant by Allan P. MacKinnon, US department of justice. This edited article covers the cross-examination by Mark Soler for NORML. The honorable Aubrey E. Robinson, Jr, US district judge presided. The testimony is now under study by three US Appeals Court judges whose decision is expected early next year.*



Harold Kalant

Cross-Examination

By Mr Soler: Dr Kalant, at the beginning of your examination, you talked about the question of how long it takes to find some of the problems from use of other drugs, alcohol and some of the other drugs. I believe you indicated that it took dosage of eight to 10 ounces of alcohol per day over a period of 10 years to show cirrhosis of the liver?
Yes, if I can amplify on that just a bit. That should not be seen as an absolute threshold. The way this type of investigation is done, that an epidemiological study is done, is to examine the record of a large number of patients with cirrhosis to compile detailed drinking histories in terms of average daily amount over a time, and calculate exposure as amount by time, and plot the frequencies of these different exposure levels among patients with known cirrhosis or, conversely, to plot the number of cases of cirrhosis appearing among people at a series of different drinking levels.

And this is the level at which the risk becomes appreciably different from the general population, and it increases progressively in increasing amount and duration.

What would that be? What would eight to 10 ounces of alcohol be in terms of joints, marijuana?
In terms of the social, so-called social, dose, I would say that roughly, a drinking — a standard drink of alcohol is comparable in terms of the duration and/or effect to the ordinary joint of weak marijuana.

How many joints would eight to 10 ounces of alcohol be?
If you calculated the average drink as an ounce and a half, eight ounces would be approximately five, or five and a half drinks a day. That would mean then approximately five joints a day.

All right. Now, if someone drank eight to 10 ounces of alcohol a day for 10 years, can we say that there would be an indication of cirrhosis of the liver after that period of time?
No, no. We can say that if you examine a large number of people who use that amount, then there will be indications of cirrhosis in a certain percentage of them.

All right. If a person used that amount of alcohol every day for 10 years, isn't it true that they would have other physiological symptoms from using that much alcohol?
Symptoms?

Yes.
Yes, certainly they would have the physiological symptoms of the intoxicant effect minus whatever degree of tolerance they acquire. Many people who drink larger amounts than that . . . are never seen to be intoxicated, they drink a lot every day and they build up a striking level of tolerance.

In fact, in what they traditionally call the French style of drinking in what the French themselves refer to as "the drunkard without drunkenness", they may consume considerably larger amounts than that and still continue to work, to carry on an apparently normal pattern of activity, and never be visibly drunk.

Would they have physiological symptoms that could be measured through examination?
Yes, they would.

What would their symptoms be?
Most of them would have effects, for example, on heart rate; they would have effects probably, if not cirrhosis, many of them would have enlarged liver, or they would have certain changes in some enzyme and so forth.

So that if you took a group of people who had drunk eight to 10 ounces of alcohol a day for 10 years and examined them very carefully, you would be able to tell whether they were alcohol drinkers over a period of time?
Again, I must emphasize you are talking about probability.

Yes, but probably you would be able to?
Well, what I am saying is that you would be able to find out in a certain percentage, . . .

All right.
. . . not in everyone. That is the point I am making.

Is it fair to say that at least in a large percentage of them, you would find some of the physiological symptoms like enlarged liver or something of that nature?
In patients who are admitted to clinics with either some identified alcohol problem or diagnosed alcohol problem, approximately 20% of them have some enlargement of the liver, or some enzyme, or some body chemical disturbance which goes with that.

All right.
Four-fifths of them do not.

My only point is that if you have a population using it at this dosage level with the frequencies for this period of time, you would at least be able to identify them with some degree of likelihood by examining them.
No, I would change that. I would not accept it quite that way. I would say that the probability is that you would find some minor abnormality in a substantial proportion of them, yes.

All right. Now, Dr, is it not true — well, what was the dosage level of cannabis used by the subjects in the Jamaican experiment, if you recall?
My recollection is that they used 10 or more joints a day.

All right. And would that be at least equivalent or more to eight to 10 ounces?
Yes.

And do you recall about how long they had used that amount?
Yes, there were some who had used that 14 years or more.

Do you recall what the average time was?
I do not recall the average time.

Okay. But it was for a very long period of time?
It was for a long time. I believe a minimum of 10 years.

All right. So what we are talking about is a sample of that, that was, say, roughly equivalent to your group of alcohol drinkers, eight to 10 ounces of alcohol per day for 10 years?
Yes.

All right. Is it not true that the findings in the Jamaican study were that you could not identify that group because there were no significant differences between the cannabis users and non-users?
No, that is not entirely true. There were many minor differences to which no pathological significance was attributed, but which would mark them as different from non-users in the same way that the things that I mentioned apply to the regular heavy alcohol users as opposed to non-users. The percentage of alcohol users who would show overt pathology which can be diagnosed — that is smaller. I must emphasize that.

In the Jamaican study, were there significant differences that were found between the users and the non-users?
Yes, there were differences in a variety of things in relation to their work differences, in relation to a number of these physiological things.

I cannot recall specifically in the Jamaican study. But in the Greek study and the Costa Rican study, there were a number of biochemical differences in the levels of serum potassium, levels of globulin or A/G ratio.

Were these differences attributable to the cannabis use?
Well, this type of study does not permit you to say that they are attributable. This type of study tells you that they occur in users.

You have to do specific direct experiment in order to say whether they are attributable causally. You infer that they are related.

Would you agree with this statement regarding the Jamaica Study, Costa Rica Study, Greek Study: "A wide range of measures were employed in these studies to detect physical or psychosocial consequences of use. In general, few differences were found that could be directly attributed to cannabis use."
I would agree with that by saying provided the last part of it — about the differences, is made quite clear. Notice that you said "few differences," not "no differences." And you also read the statement that said, "which could be directly attributed to it." I would say, yes, provided one recognizes that to mean causal proof.

All right.
May I comment just in general? I think there is one thing which is important to note here, too, in relation to what the investigator or the reader of an investigation accepts as being a significant difference. To some extent, what one chooses to consider as significant difference reflects the expectation one has, what one is looking for, and how stringent the criteria are that apply to the test, whether the difference is significant or not.

One of the studies, a chronic study, the Greek study, which compared a matched group, I believe, of 30 regular heavy users with non-users, reported that there were no significant differences in terms of brain function as related to ability to carry out certain tests of intellectual and motor performances and so forth — memory, problem solving — tests of various kinds.

I looked before coming here and tabulated the results of the Greek study. And what struck me was that in spite of that statement, three of the approximately 15 items in the test battery did have sufficiently significant differences in the expected direction which the investigators themselves listed in their table. They commented on them, but did not for some reason take them as being evidence of differences between the groups.

They found a memory difference, a poorer performance on the memory test in the users than in the non-users; and they found two significant differences in the rest of the adult intelligence test battery.

And if you look at the whole 15 items, even though item for item the remainder did not show significant — statistically significant — differences between the two groups, the performance, the score of the regular users was worse than that of the non-users on 13 of the 15 items.

If you apply what are known as non-parametric statistics to that, that is a significant result in itself. In other words, even if the result on each test individually is not statistically significant, the result or the fact that out of the 15 tests, 13 gave a poorer result for the users than for the non-users is a significant result.

And I am puzzled as to why they concluded that there was not a significant impairment of the intellectual performance in the users.

Well, the statement which I read to you before, of course, comes from the Sixth Annual Report to Congress from the HEW.

Let me read you a statement from the Fifth Report that is about the Greek study and see if you agree with that. This is on page eight of the report, and it goes as follows with respect to the Greek study: "A variety of neurological, psychological, and physical measures found few changes attributable to cannabis use. Heavy emphasis was placed on possible brain damage as measured by electroencephalographic and ecoencephalographic and psychological test procedures. None of these measures showed evidence of brain damage." Do you agree with that statement?
No, I do not agree with it. That is what I essentially said.

You do not agree with the HEW Report?
No, the HEW Report states correctly what the investigators who carried out that study concluded. What I disagree with is the conclusions made by the investigators themselves. I cannot understand on scientific grounds why they reached that conclusion in spite of their own findings.

All right. Now, you testified on direct about alleged impairment of motor performance involving car driving. You did discuss to some extent the research of the LeDain Commission and their recommendations.

Is it not true that the LeDain Commission, in fact, was aware of these studies on the effect of cannabis use on driving?
Yes, the LeDain Commission was not only aware of it but took direct cognizance of it, and discussed it in the report.

All right. And is it not also true that the LeDain Commission did — four of the five commissioners recommended elimination of criminal penalties?
That is correct, for possession.

All right. And did not the LeDain Commission also make a distinction and not recommend elimination of criminal penalties for driving under the influence of marijuana?
That is also correct.

All right. Do you agree with that distinction?
I'm sorry. May I ask for clarification? By the question, do you mean am I in sympathy with their recommendation?

Do you think it was a reasonable distinction to make?
Oh, yes, I think it is a reasonable distinction to make. I think there is evidence and precedent in the law for distinguishing between the use of alcohol, for example, and the conduct of certain behaviors while intoxicated by it.

All right. Now, with respect to the question of panic reaction and toxic psychosis that you mentioned, do you, by the way, have any information on the number of cannabis users in Canada?
Yes, the current figures, according to the most recent survey conducted by my colleagues at the Addiction Research Foundation, placed the use at slightly less than the current use in the United States. In other words, it varies with age. It is highest among the teenagers and young adults, and it tapers off progressively in older age groups through the 30s; and by the time of the age of 40, there is very little use.

And among the groups with the highest level, late high school and college groups, the use is roughly in the order — "have-you-ever-used" figures are in the order of 30%, or possibly more in larger cities and substantially less than that in small towns and rural areas. Current use is considerably less. Current use is estimated probably somewhere in the area of 10%. And regular daily use is probably fewer than 5%.

Can you give us a rough estimate of the round number as to ever-used and/or current use in Canada?
No, off the top of my head, I do not think that I could give it. I would have to calculate that from the population figures.

Do you have any information on the number of people in the United States who ever use marijuana and who currently use it?
My understanding is that the have-you-ever-used-it figure is in the range of 20 or 30 million or more.

And how about current use?
Current use, I believe, is estimated somewhere in the range of 10 to 12 million.

...scientists in the courtroom

Now, with respect to the question of the panic reaction, do you have any information on the frequency or incidence that those reactions occur or any studies which have measured the frequency or incidence of those reactions?
No, because these are — these have not been — the type of epidemiological survey would be needed to establish that, and that has not been done.

What have been reported have been a series of cases, case reports, individual observations, accumulated experience over a period of months and years in individual clinics or survey of an emergency treatment facility in the United States and so forth. This does not enable you to make a figure of the total current in the whole range of population.

I believe you indicated that these reactions generally occur among inexperienced users who get an overdose for some reason?
Yes.

And it is not true that these panic reactions are actually so rare that they are reportable in the scientific literature?
No. I think that is a fallacy. The reportability is not in direct proportion to the frequency of occurrence. It really reflects the degree of interest in the problem, I think, at the time.

They are reportable at first when they are first observed and their existence has not been known. They are then reportable in the sense that editors are interested in accepting a case report for publication when there is a particular concern about it, where there is a lot of attention to it.

When the amount of attention falls off, or the amount of concern falls off, then the numbers of case reports tend to dwindle. And one sees a recurrence of interest only if a debate is raised about it and the matter is under observation; so it is rather sporadic, ups and downs in fluctuation of the frequency of the case reporting.

Now, you mentioned the article written by your wife about the Indian Hemp Drug Commission Report; and you indicated that — I believe you said smoking cannabis was not common until the last couple of decades in India.
Smoking marijuana?

Yes.
Smoking of ganja, charas, that is not — never has been common; but it has been listed in the medical literature on regular users for at least a century or more.

And is there not another preparation of cannabis used in India called bhang?
Yes, there is.

And that is eaten?
That is swallowed.

Swallowed?
Yes.

All right. And is it not true that consumption of bhang has been common for a long time in India?
Yes, as I pointed out, bhang is used on ceremonial occasions but it is not a regular practice.

It is your testimony that bhang is not being consumed on a regular basis by many people in India?
By many people? Yes, that is correct. It is consumed by a very small percentage as I understand it.

Is it not true that bhang is used rather regularly by members of lower castes?
No, that is another misconception. It is used by a very small percentage of people, primarily of the lower caste. But as a percentage of the population, it has been repeatedly estimated as less than 2%...

Now, with . . .
. . . compared with better than 10% for alcohol, even in a country where alcohol use is supposed to be low.

Now, with respect to the so-called amotivational syndrome, you discussed the research that you have done with rats in your own laboratory; and I believe you have indicated that you thought there was applicability of that research to some extent to human beings. But I take it, there are also some limits to application?
Yes.

Would it be fair to say that the research on the rats is not any more applicable to human beings than actual research done on human beings?
Well, clearly, it is not more applicable. The most applicable work would be research done on human beings. But as I pointed out, the reason why we like to do research on animals is that many of the most important complications, the most serious ones, the ones that one is most interested in, cannot be tested by experiments on human beings because it would not be ethical to do so.

Are you familiar with the report of the National Marijuana Commission of the United States?
Yes.

Is it not true that the National Marijuana Commission found that there was no evidence to support the existence of amotivational syndrome?
No, that is another frequently incorrectly stated thing. That is stated in Dr Grinspoon's book and Dr Zinberg's recent article in *Psychology Today*. These statements are not correct. If you look at the marijuana report and if you look at the LeDain report, where there are very similar conclusions, what they say is that the evidence to date does not permit us to reach a definite conclusion on the existence of an amotivational syndrome. The connection between them has not been clearly established.

That is not saying they do not exist; it is that we just do not know.

Well, is it fair to say that both the National Marijuana Commission and the Canadian LeDain Commission concluded that the existence of an amotivational syndrome had not been demonstrated?
Had not been proven. That is correct. They did not say that it did not exist; they said that the evidence was not conclusive.

All right. Are you familiar with this volume of *Pharmacology of Marijuana*?
Yes.

This is in evidence. I show you Volume II. I would direct your attention to an article beginning at page 643, entitled The Effects of Marijuana Use on Human Operative Behavior: Individual Data. And I would ask you to read the last sentence — or let me read it, and you tell me if you agree with it.

The last sentence of the actual article on page 652 states as follows: "These data" — that is, data from the study — "do not support the hypothesis that marijuana induces an amotivational syndrome."

Do you think that is a fair statement regarding this research?
That is a fair statement of conclusions by these investigators regarding their own results, yes.

All right. Now, . . .
I would say, though, that that is not a fair statement of the whole body of evidence. They do not attempt to draw that conclusion from all of the evidence which has been adduced concerning an amotivational syndrome.

They are making statements about their own findings. And I would have to point out that this is the same study in which no effect on testosterone level was found, in which no effect on the work performance was talked about here, in which very little of a disturbance of any kind was found.

And since other studies have reported disturbances of various kinds, including work performance, including motivation and ability to make decisions and so on, a necessary consideration then is, how does this study differ from the others: Was the exposure to marijuana equivalent in this and in the others?

And on the basis of a best scientific guess, it would seem to me that many of the discrepancies are best reconciled with the probability that these subjects were younger, healthier, had shorter periods of exposure, and had less intense exposure to the drug in this study than in the studies which do report those findings.

Because, again, I do not wish to challenge the scientific validity of those studies in the literature. Rather, I would say that they are done — all of the studies are done — by people with good scientific training, or most of them are, with the desire to find accurate information.

And, therefore, where there is discrepancy in the results, I think the explanation is likely to lie in the difference in dosage, difference in circumstances, difference in the subjects. So that I would say this statement is a valid statement for this study. I think the studies in which lesser work performances have been found are valid statements for those studies.

All right. Are you familiar with the study conducted in 1973, or reported in 1973, done by Joel Hoebman and Norman Brill at UCLA?
Yes.

That was a study on UCLA college students. Is that correct?
That is right.

Is it not true that they also found there were no amotivational differences between cannabis users and non-users?
Yes, that is what they reported. But if you look then at the follow-up studies done by the same group, by Brill and Christie, which was the same group of students at the University of California, followed up a year later, two years later, you find that the picture has changed and that among the heaviest users there is, in fact, a higher dropout rate, a greater incidence of emotional problems. That same paper by Brill, by Hochman and Brill, states explicitly that the use of cannabis by the subjects in the research could not be attributed to pre-existing psychiatric or personality disorders.

Therefore, the impaired behavior which they found in the heaviest users, in the follow-up study, was then logically attributable to the use of cannabis.

Is that your belief?
Yes, that is my belief.

Is that what these things say?
No, that is not what they say. They point out that there were more dropouts. They point out that there was worse emotional adjustments, worse academic adjustment in the heavy users. They do point out — and I think in fairness this must be stated — that the light users showed a better adjustment, better performance; and I think this is probably correct.

I think it is compatible with the fact that many college students using small amounts of cannabis are doing what is current in the scene among their associates, among the society in which they move; and a good adjustment to that society is quite likely to go together with the use of small amounts of cannabis.

On the other hand, the heavy users — and these are the ones that I am concerned with — they themselves point out they have poorer academic adjustment, poorer emotional adjustment, higher drop-out rate, a great amount of uncertainty about what they want to do in life, and where they are going.

And despite these comments, they conclude that overall there is really no demonstrable major effect of cannabis on these functions. I agree with them that there is no overall effect of cannabis on these functions. But we are not really interested in the overall effect; we are interested in the effect of heavy use because there is no overall effect of alcohol on these things either. A great majority of people who use alcohol are not harmed by it in the least. It is only the heavy users who are harmed.

Therefore, I think to concentrate on group differences and say "cannabis users are not harmed by it" obscures the fact that heavy cannabis users are. This is the point I am making.

So I take it that Brill and Christie concluded that this cannabis use — or that the users were not harmed by the cannabis use in terms of loss of motivation. You disagree with that conclusion?
No, I do not disagree with their general conclusion that the whole body of users were not. But what I say is that though they themselves pointed out the harmful effects or the increased incidence of undesired development in the heavy users, they failed to comment on this specifically in their conclusions and to differentiate the effects in heavy users from the effects of the use globally, which again to me illustrates, as I said before, a rather disconcerting difference in the way in which the evidence is evaluated in relation to cannabis compared to other drugs.

Because if one looked at use for alcohol, then everyone would say alcohol use or heavy alcohol use has undesired effects of such and such a type. Yet in many instances, one finds that in relation to cannabis, though heavy use has undesired effects as shown by the very data themselves, the conclusion is often in relation to the whole body of users rather than heavy users.

As a general matter, is it not true that most people in the United States — I guess in Canada, too — use marijuana occasionally or intermittently?
Yes, that is correct.

All right. Now, you discussed the research which you did, which was reported in your articles on — two articles — one on residual learning deficits and one on what you call permanent learning deficits. Is that correct?
Yes

My understanding of your testimony was that at the dose of 10 milligrams per kilogram in the rats, there was no significant learning deficit; when you doubled the dose to 20 milligrams per kilogram, there was a learning deficit?
That is correct.

All right. I would like to read you the last paragraph of your reported article and just ask if you still agree with the statements that are in there as follows — this is on page 1,251 of the reprint which I was given — as follows:

"It should be noted that no residual impairment was found at the THC dosage of 10 milligrams per kilogram daily for three months; so that a very high level of cumulative exposure seems necessary.

"The effective dose of 20 milligrams per kilogram cannot be applied literally to humans for two major reasons: The first is that rodents are much more resistant than larger species to most drug effects on the central nervous system. The lowest intravenous dose of THC reported to produce significant effects on electroencephalographic recordings is 1 milligram per kilogram in rats and .5 milligrams per kilogram in rabbits.

"The second is that much larger doses of cannabis are required by mouth than by intravenous or intrapulmonary administration to produce comparable effect.

"In fact, the cannabis-administered animals were visibly intoxicated for only about four hours after each dose, gained weight normally, and were in good general health throughout the experiment.

"The 6 grams per kilogram dose of ethanol would also be lethal in humans, yet even though it produced some general impairment of health in rats, it was fairly well tolerated."

Is that an accurate statement?
Yes, it is.

Now, as I understand it, the paper which was reported under the title, Permanent Learning Impairment After Chronic Heavy Exposure to Cannabis or Ethanol In the Rat, and was reprinted in this volume, was a continuation of that study?
No, it was not. It was a presentation at a conference of that same study.

I see. It was the same research?
Yes, it was the same research; it was exactly the same as that which has been already published.

I see. And with respect to the published study, it is my understanding that what you did — a year later, you took the surviving rats and tested them again?
No. Six months later, we tested them; a year later, we did the electrode implantation and the recording of electroencephalographic activity in the brain.

All right.
That was the first one. The second study was done more systematically. The electrode implantations and recordings of electroencephalographic activity was done immediately after the determination of learning ability — the second study.

The second study has not been published?
No.

All right. Now, with respect to the published study, I believe the paper indicates that what you were looking at at the end of the year when you were checking through the electrodes was really one of the control rats, two of the alcohol rats, and two of the marijuana rats. Isn't that correct?
That is correct. That is why I did not refer to that. What I said in relation to the electrode study, what I described before, applies to the second study, . . .

Okay.
. . . which included substantially larger numbers.

That is because at the end of the year there just were not too many rats left?
There were not too many rats left.

All right. Now, you referred to Dr Heath and the research that he has done. Is it not true that Dr Heath's research previously on the effects of marijuana have been strongly criticized by the members of the scientific community?
They have been criticized by some members of the scientific community, but I would not say — I do not think it is correct to say that they have been generally condemned. I think there have been a number of important questions asked about them, such as, "What is the validity for the selection of the dosage used?" and . . .

And what is the criticism with regard to dose?
Well, the criticism really is that the doses are very high

To that, I would repeat what I said before: I do not find that a criticism, because if the

purpose is to determine the effects of high dosage use, then, obviously, you have to give high dosage, to elicit high dose effect.

If you want these to illustrate the consequences of the typical average low dosage, then, obviously, they are inapplicable.

In other words, Heath's findings, in his earlier research, are not applicable to low dosage?
That is right.

All right. Do you recall about what the equivalent dose was he giving?
Well,. . .

Well, first of all, what kind of subjects was he using?
These were monkeys.

And is it not true that he was force blowing cannabis smoke into their lungs?
What do you mean by "force blowing"?

Was he not blowing cannabis smoke into them?
Well, they were made to inhale cannabis smoke.

All right. And about what was the equivalent — what was the equivalent marijuana dose in terms of joints, for example, to what he was giving the monkeys?
He was giving dosages, as I recall, on the order of a couple of hundred milligrams per kilo a day, which would probably be in the range, if one equated them literally, as I recall, of somewhere in the range of 50 joints per day.

Yes. Okay. Now, with respect to . . .
May I just add a comment on that again. I think — I feel I am obliged to make the comment over and over because . . .

The Court: Well, I think your point has been well made. And we understand, as lawyers, what is going on in terms of how they are interpreting the data.

I think you have made your point. The underlying assumption with respect to those who are interested in demonstrating that there are not significant harmful effects is based on the premise that you have to talk about a statistical average of the population of users.

And if you take that premise, there are no such things as harmful drugs because among 220 million people, if you average it out, nobody is taking harmful doses of heroin.

However, if you confine yourself to the using population and then if you screen the most heavy users at least for experimental purposes, you are going to find demonstrable ill effects upon the human body.

That is what you have said. That is what you have said several times during the course of your testimony. Is that not correct?
The Witness: That is correct.

The Court: And for experimental purposes, you have to do that. Because if you use an average situation for experimental purposes, you get nowhere; you come up with nothing, especially if you have a statistical base as large as two, 10, 20 or 100 million people. You get nothing out of it. And no scientist can operate on that premise. He has to take an extreme.
The Witness: Or at least a range.

The Court: A range, yes. So I think as to that point, I think I understand it. You have stated it several times on the record. I do not think you have to state it again.
Mr Soler: May I have a second, Your Honor?
The Court: Yes.
[Mr Soler confers with co-counsel.]

By Mr Soler: Dr, I think you indicated early on that you did testify before the Canadian Legislature about a decriminalization bill?
A committee.

All right. And what are the provisions of that decriminalization bill?
The provisions of that bill are to remove cannabis from the narcotic control legislation, to include it under the appropriate schedule of the Food and Drug Act, which would have the effect largely of removing criminal records for simple possession and making lighter penalties, although it would retain the ability to apply quite strenuous sanctions against trafficking.

Did you testify in favor of that bill or opposed to it?
I did not go to testify either in favor or against. I went at the request of the Senate to provide scientific evidence and how an explanation of the scientific evidence bore on the basis of a decision.

Were you asked whether you favored the bill?
The Court: Whether he favors it or not is immaterial.

Mr Soler: Well, Your Honor, it is the main issue that is involved here.
The Court: No, it is not. No, it is not.

Mr Soler: The decriminalization penalty.
The Court: No, that is not the issue that is involved here. That is what I have been trying to tell you throughout these proceedings. It has nothing to do with whether he favors it or does not favor it. That is not what these experts have talked about. That is not why they were permitted to testify, whether they favored or disfavored.

Mr Soler: Your Honor, the question, as we see it, is whether the effects of marijuana justify decriminalization of . . .
The Court: That is the scientific effects. We are not talking about any value judgment as to what they think ought to be done. That is not what this case is about. I told you that years ago. It is not going to be decided on the basis of whether we think it ought to be decriminalized. That is not it. It has nothing to do with it.
By Mr Soler: Dr Kalant, is it fair to say that in small doses with occasional intermittent use, the effects of marijuana are not consequential or do not have harmful health consequences to the individual?
Yes, I think that other than the instance that I mentioned, the ability to drive a car or to fly an airplane, generally speaking, the effects of small doses, occasional use, are not demonstrably harmful to the health.

The Court: Well, if you drive your car out in the middle of nowhere, it would not make any difference. It is where you drive it.
The Witness: It is how you drive it.

The Court: If there is nobody else on the road, it would not make any difference.
The Witness: No, that is not quite correct because a certain number of accidents occur even where there is an empty highway where the drivers go off the road.

Mr Soler: I have no further questions.
The Court: All right.
The Court: You may inquire.
Mr MacKinnon: No redirect, Your Honor.
The Court: Very well.
The Court: Dr Kalant, you may step down and be excused.
The Witness: Thank you, Your Honor.
[The witness leaves the stand.]

The Court: Mr MacKinnon?
Mr MacKinnon: Your Honor, that concludes the Government's case. We have an exhibit or two that we would like to move. And you also have exhibits that you would like to move?
The Court: No, they have moved all of their exhibits. What exhibits do you have?
Mr MacKinnon: Is there any objection — I would like to move into evidence Defendant's Exhibit 6 for identification, Your Honor.
The Court: What is that?
Mr MacKinnon: The Novotny article on A Possible Chemical Basis for the Higher Mutagenicity of Marijuana Smoke as Compared to Tobacco Smoke.
Mr Meyers: Your Honor, we do not object to that, but we would like a copy be provided us.
The Court: You have no objection?
Mr Meyers: We have no objection.

The Court: It will be received without objection.
Mr MacKinnon: Thank you.
The Deputy Clerk: Defendant's Exhibit Number 6 received in evidence.
[Defendant's Exhibit No. 6 for identification was received in evidence.]
The Court: Is there anything else, Mr MacKinnon?
Mr MacKinnon: That concludes the Government's case, Your Honor.
The Court: All right.
The Court: Mr Meyers?
Mr MacKinnon: We are assuming that there is no objection to the curriculum vitae.
Mr Meyers: No.
Mr Soler: Your Honor, our rebuttal witness, Dr Zinberg, is not here in Washington right now.
The Court: Give me a proffer on his rebuttal. I have heard about rebuttal, about rebuttal. Rebut what?
Mr Soler: There has been a great deal — there has been — I believe there has been testimony about a number of issues that there is to some extent debate about, and Dr Zinberg can clear up the debate.

I think that with Dr Szara, there were no central things that we would disagree with or that Dr Zinberg would disagree with; but he did mention a number of things that I think should be cleared up. For example, when talking about lung function, he was asked about Dr Tennant's study on lung function; and he did not know the dose that was given, and he did not know the relevance of that dose to use in the United States.

I think that is an important thing to clear up because our investigation reveals that the dose was completely aphysical and was an enormous type of dose.

Dr Szara also had some methodological criticisms of the Greek study, which I think is proper to introduce rebuttal testimony on. He also said that marijuana is more difficult to study than other drugs. I think that Dr Zinberg would testify differently.

With Dr Jones, . . .
The Court: You could have asked those questions of him. You could have asked those questions of the other experts.
Mr Soler: We did not know what the testimony . . .
The Court: You did not know what?
Mr Soler: We did not know what evidence Dr Szara would testify to. I could not ask the question before he testified.
The Court: But after he testified. You've got another expert on the stand. You can ask him. He studied that, he testified, as far as 10 years ago.
Mr Soler: Well, he testified — I do not think we are required to ask the Government experts if they all agree with each other.
The Court: No, that is not the question. It is not a question of whether he agrees with anybody, but what was his own personal experience. You did not ask Dr Kalant that, for example.
Mr Soler: No, I did not.
The Court: Well, . . .
Mr Soler: But I think it is proper to present rebuttal evidence on that.
The Court: Why?
Mr Soler: Because I think the witness will testify differently based on his own experience with the drug.
The Court: There is no difference, It is just as easy to do one as it is to do the other.
Mr Soler: Well, there were a number of areas that were raised by Dr Jones in areas that he considered — well, there were a number of these in Dr Jones' testimony that I think would be proper for rebuttal testimony.

For example, he said we need to know everything about the drug, all of its effects on all people. Dr Jones is a — he testified he is a research scientist and that his experience with marijuana is confined to the research lab. He is not a person who has been involved at all in any kind of broader decision involving cannabis.

Dr Zinberg is in quite a different position. He has been involved in research of cannabis on human beings over a long period of time. He has also been involved in looking at some of the larger issues, and he is the chairman of the Liaison Task Panel of the President's Mental Health Commission.
The Court: That is why I cannot understand why he was not one of your principal witnesses. That is exactly what I told you before the trial started. Now you want him here for rebuttal. Here is your strongest witness; he has had clinical experience, practical experience, laboratory experience; now you tell me that you want to bring him on as a rebuttal witness.
Mr Soler: Your Honor, he has written one of the most recent and leading articles on the various research in marijuana.
The Court: That is exactly what I am talking about, counsel. That is what I told you at the outset. Rebuttal is rebuttal. You have no right in connection with the development of your principal case to hold off your best witness that you have or one of your better witnesses and then come back and say, "Well, I have heard everything else; then we are going to bring him in; we are going to make our case."
Mr Soler: Well, Your Honor, . . .
The Court: I warned you about that at the outset of this case.
Mr. Soler: Your Honor, that is true. Our witnesses testified that, in their opinion and based on their experiences, marijuana did not cause demonstrable harmful effects in a number of various areas.

Dr Szara came on and testified for the Government that he had concern in two areas. Dr Jones came on and testified he had concern in a number of areas.
The Court: Yes.
Mr Soler: Dr Kalant testified today he has concern with a number of other areas. Now, our witnesses have testified as to what their opinions were; and the Government's witnesses have testified to some extent based upon cited studies that they have concerns in particular areas.

I do not think it was possible for us to predict what areas they were going to be concerned about. The Government's experts themselves did not agree as to what areas they had concerns about.
The Court: It is not a matter of predicting anything. We are not talking about predicting anything.

When you make your case, you lay it out. Now, you brought on psychiatrists, did you not?
Mr Soler: That is correct.
The Court: None of whom had done any of these technical experiments that you knew from the curriculum vitae that the Government presented to you were going to be involved in the defence of this case. That is the point that I am making.

You put the psychiatrists on to talk about it in the broadest sense. And then the Government — and you know in advance what the Government is going to do. They are going to bring scientists in here who have done the experiments, who have done these studies; and you know what their contention is by virtue of their pleadings.
Mr Soler: Your Honor, I do not think . . .
The Court: Now you want me to let you present your case.
Mr Soler: No, that is not true. That is not true. First of all, Dr Ungerleider is a research . . .
The Court: Do not tell me that is not true.
Mr Soler: I apologize. Dr Ungerleider is a research scientist. He is conducting research at the present time. Dr Szara testified he is not a research scientist. He is involved in reading grant applications that come in. Dr Jones has been doing research but did not testify about his own research. And Dr Kalant today has testified about his research.
Mr Sirulnik: Your Honor, may I address the Court?

The Court: I do not think you understand the point that I am making at all.
The Court: No, one lawyer to a side talks. Do you wantto talk to your co-counsel?
Mr Sirulnik: Please.
Mr Soler: May I have a second, Your Honor?
The Court: Yes.
[Messrs Soler and Sirulnik confer along with Messrs Meyers and Stroup.]
Mr Soler: Your Honor, we ask that Dr Zinberg be allowed to testify as to only the questions as to methodology and the various particular types of concerns raised by the Government witnesses. We never intended to save our powerhouse for the end or anything of that nature. What we intended to do is that if there were questions raised about the methodology of the studies upon which we are relying in part, such as the Jamaican study, the Costa Rican study, and the Greek study — if there were methodological questions raised and criticisms made, then we could present a rebuttal witness who could discuss those kinds of methodological considerations. It would not be a wide range in testimony; it would not take a great deal of time. We think we should be able to respond solely to the type of specific concerns raised by the Government's experts.
The Court: When is he available?
Mr. Soler: At 9:30 tomorrow morning.
The Court: Where is he coming from?
Mr Soler: From Boston. I certainly do not anticipate his taking very long, Your Honor.
The Court: What is your best estimate of the length of his direct examination?
Mr Soler: At most, an hour.
Mr Mackinnon: Your Honor, may the Government be heard on that?
The Court: Yes, certainly.
Mr MacKinnon: The case in substance seems to be opinion evidence on both sides as fortified by the experimental data. Everything is in the record here. We have certainly touched on a percentage, probably 20%; all of the rest is in the record here, anything that has been referred to.

What is new, what is fresh that needs to be rebutted — there does not seem to be anything mentioned here that is not already in the case one way or the other. You can interpret a study various ways.

But if you are talking about rebuttal, then presumably an interpretation that will be given to the Greek study data — that should the Government have surrebuttal, I mean when is the end to the litigation?

Mr Soler: Your Honor, I would respond to that in this way: The raw studies are in evidence. That is correct.

But as we have seen with these experts testifying, the question is how the raw studies are interpreted and the significance of those studies.

'... the heavy users ... themselves point out they have poorer academic adjustment, higher drop-out rate...'

. . . scientist in the courtroom

As Dr Kalant testified today, looking at even the conclusions drawn by the researchers may not be the only way of looking at that evidence. And as Dr Szara and Dr Jones and Dr Kalant have testified, they have characterized the various studies in particular kinds of ways and have particularly pointed up shortcomings in certain experiments.

It is only to discuss those alleged shortcomings that we would put Dr Zinberg on the stand. I think that the raw studies do not speak for themselves in terms of the significance and implication; and, particularly, because there will be two other judges reading testimony in this case, I would ask that we be allowed to put on this other testimony.

Mr MacKinnon: Your Honor, the studies have been eaten over in all the literature. The studies are there and the records. I just cannot see that there is going to be any additional advantage by having further and further interpretations one way or the other.

It is just another opinion. We have had opinions on both sides. That is what the case is all about.

The Court: That is really what it amounts to. And so far as the foreign studies are concerned, I have not heard any alleged discrepancy in how the studies were conducted. Dr Kalant described it as every other witness understood they were conducted.

Mr Soler: There is a question of how applicable they are to use in the United States.

The Court: It is a question of judgment. That is exactly what Mr MacKinnon was talking about.

You can go on ad infinitum. The way you are trying the case, we will have to bring everybody in here who ever wrote an article on marijuana because they all differ, all over the lot.

We could parade experts through here for the next month: "Do you agree with this conclusion?" "Yes, but . . ." "No, but . . ." "My information says so and so and so and so."

Psychiatrists say we ought to explore this, pharmacologists say we ought to explore that. That is what the testimony is. We could go on and on.

Mr Soler: We would only bring Dr Zinberg in to discuss the methodological questions that have been raised. It will be very limited testimony.

The Court: Well, I will permit his testimony; I will permit the examination only because I do not want to leave anything unturned or undone, no stone unturned, in winding up and concluding all the evidence that you think is relevant to the issues. We have a lot that is irrelevant.

Mr Soler: Thank you, Your Honor.

The Court: I think 10:30 would be early enough.

Mr MacKinnon: Your Honor?

The Court: Yes?

Mr MacKinnon: At this time, do you wish to emphasize the scope of the rebuttal specifically, or will we take that up tomorrow morning?

The Court: I will handle that question by question. And I think we have had it articulated rather clearly what the rebuttal is going to be about.

Mr Soler: Thank you, Your Honor.

The Court: All right.

The Court: I cannot predict what questions will be asked; but if they are not, in the judgment of the Court, rebuttal questions, I will not permit them.

Mr MacKinnon: It seems to me that the overseas studies are the scope of the rebuttal.

The Court: There will be some other things. There will be some other studies that he will refer to, if they are within the competence of the witness and if he knows anything about them and knows anything about the methodology.

But I suspect this will not take more than an hour. I think 10:30 will be early enough to resume this trial, and the Court will be in recess until 9:30 tomorrow morning.

Mr Meyers: Your Honor, may I be heard briefly?

The Court: Yes.

Mr Meyers: Your Honor, we would like to make a very brief closing presentation after Dr Zinberg's testimony.

And even more important than that, Your Honor, we feel that after the case has been briefed, perhaps we could schedule . . .

The Court: How many times do you want to argue to me? Why should I hear you before you even submit your proposed findings and your conclusions? Why?

Mr Meyers: Well, our perception was that it might be useful for Your Honor right after hearing . . .

The Court: Why? I know what this case is about. I have listened very intently to every one of your witnesses. And your oral persuasion, your oral argument, is not going to make the difference. The difference is going to be in the evidence and the finding of facts and applying the law to it. You can argue and I can give you a week to argue, and it will not persuade us one way or the other. It will not because what you say is not evidence.

And we know how you view the evidence. It is very clear what the contentions of each side are with respect to the testimony of every one of these witnesses.

I would think that after we take the testimony, have some discussion about the briefing schedule, then when you are all set, we will schedule it for the three Judges to hear you. And we will give you an hour or so to summarize your arguments.

That, to me, is much more effective than to argue to me and take an hour or two. Because you are eloquent and I do not care how eloquent you are, it is not going to decide this case. And your emotions are not going to decide this case. So I think that is what we are going to do.

The Court: Yes, Mr MacKinnon?

Mr MacKinnon: Just one final matter, Your Honor, and that is if new data is presented by Dr Zinberg, . . .

The Court: Yes, we will bounce the Government back into the picture so that the Government can present its witnesses, yes. But new data will not be presented; it will not be.

Mr MacKinnon: Thank you.

The Court: They are going to talk about the contentions that have arisen with respect to the validity of some of these studies from which conclusions have been drawn on both sides. They are going to start, I assume, focusing about the attention that has been given to the so-called foreign studies; but they will not be limited to that because there are other studies that some suggestion has been made.

There were no dosage controls. The witnesses did not say how much the dosage control was and so on and so forth.

They are going to argue over the comparability of the studies involving rats and human beings, whether there is a valid explanation and what it takes to determine it.

They are going to argue over whether or not six months is long enough and would it not have been better for a year. We will get opinions on that. So we will take that up tomorrow morning at 10:30.



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Migrating nomads in Hindu Kush Mountains, Afghanistan
A radical cultural and economic transformation will be required to end illicit opium cultivation.

AFGHANISTAN: *New leaders committed to help stem Middle East heroin flood*

By Thomas Land

GENEVA — A report by Bror Rexed, executive director of the United Nations Fund for Drug Abuse Control, has assured the International Narcotics Control Board that Western Europe can rely on the cooperation of the revolutionary rulers of Afghanistan in an international effort to stem the flood of Middle East heroin.

The UN official returned recently from consultations in Afghanistan where he signed an agreement for international assistance worth $350,000 for the prevention of drug dependence in the province of Badakshan.

His description in detail of the agreement, and his related conclusions, are being considered by a conference of the narcotics control board in Geneva this month.

Afghanistan has emerged as a principal source of illicit heroin reaching the prosperous and desperate black markets in the cities of the European Community. Narcotics agents believe the Afghan produce reaches Western Europe through Iran, Turkey, and Greece, and is being brought into the Community and other rich European nations in small quantities by "guest" workers.

'Marxist'

The new, Soviet-oriented administration in Kabul assumed power earlier this year. The attitudes of its "Marxist" rulers to cooperation with the international community have been something of a mystery. Now the administration has expressed its determination to stamp out illegal opium cultivation in the country within two years.

There is no reason to doubt the sincerity of the government in its desire to achieve that. But its ability to bring about such a radical transformation in the rural economy and culture of many wild hilltribe regions in the country is another matter.

Bumper harvest

A spokesman for the narcotics control board here observes illicit opium poppy cultivation in Afghanistan appears to have been on the increase for some time. It has just had another bumper harvest.

Last December, Denmark made available about $400,000 from development aid funds for a project of health care there, aimed at the prevention and treatment of drug dependence. Development aid finance had never been used for projects to combat drug abuse before a Scandinavian initiative earlier last year.

The new agreement of international assistance described to the narcotics control board here seems to be only the first of a series of imminent cooperative arrangements between the UN organization and the new rulers of Afghanistan.

An official statement released after Dr Rexed's return to Geneva emphasized the new government's long term policy to eliminate cultivation of opium poppy through various income substitution and other compensatory schemes intended to benefit the peasants. It also promised further UN assistance in law enforcement, agricultural development, and rehabilitation of drug addicts.

Such cooperation is certain to attract the financial and political support of Western Europe. More than a quarter of all illegal heroin seized by the law enforcement agencies of the Community are of Middle East origin. There are fears Afghanistan and its neighbors may indeed take over from the notorious Golden Triangle region of South-east Asia as the main supplier of the continent.

Specialist delegates attending a recent Interpol conference in Paris were told the movement of heroin into Europe is far easier from the Middle East than from the Far East because the supplies can be moved overland, and because traffickers make use of large numbers of migrant workers travelling to member countries of the Community.

Interpol has worked out a scheme to stem the tide through a cooperative arrangement linking the customs authorities of Western Europe and the Middle East for the first time.

There are also plans for a computerized system of data processing to digest all reports on the organization of drug smugglers and the movement of supplies, similar to the intelligence pool used by Western Europe against political terrorists.

Funds for the anti-drug drive may well come from the development aid budgets of European countries.

During its first four years of existence, the UN drug abuse control fund received $15m from the United States, $608,000 from Canada, and $355,000 from Britain as well as small, token donations from other countries. Norway last year became the second biggest donor with a contribution of $5.4m, deploying development aid finance for that purpose for the first time.

The other members of the Nordic Council have followed Norway's example, and have also urged prosperous countries elsewhere to join them in a generous and sensible approach to eliminating the supply of illicit drugs by providing opium poppy growers with an acceptable alternative means of livelihood.

Norway expects its initiative to lead to an intensified and coordinated international effort to reduce illicit poppy cultivation and to increase food production in the regions of crop substitution. Such projects in the past were financed from strictly limited funds but, as a Norwegian spokesman recently put it, a better use for development aid funds can hardly be found.



Country people are intended to benefit from the government's long term opium elimination policy which involves income substitution and compensation.

Ban on cigarette advertising urged for EEC countries

BRUSSELS — The European Commission here has launched a study on the economic and public health aspects of tobacco consumption, expected to reinforce governmental measures throughout the nine member Community.

It is now accepted that tobacco kills four times as many people as car accidents and, with 43 European Commission directives so far on road traffic, lobbyists insist Brussels should have declared war on tobacco a long time ago.

One of the most influential pressure groups is the Bureau of the Consumers' Consultative Committee (CCC). The bureau has told the commission it should give priority to the public health hazards of smoking. The statistics it has produced are astonishing:

In Britain, tax revenues raised from the sale of tobacco products amount to some £1,600m a year, compared to an annual loss of some £4,500m which CCC describes as the social cost of smoking. Social cost in the bureau's accounting comprises sickness benefit payments, medical care, the number of workdays lost (50m in Britain), and damage caused by fire as a result of smoking. The statistical relationship between tax revenues and social cost of smoking appears to be constant throughout the rich world.

CCC has asked the European commission for a complete ban on tobacco and cigarette advertising in the Community. Again, it backs its recommendations with statistics showing that, in the member countries where such restrictions have been enforced (such as Italy), the loss of advertising revenue has not hurt the commercial media. The bureau also wants a ban on the financial sponsorship of artistic and sporting events by tobacco companies, which is currently increasing throughout the Community.

Consumer awareness is the focal point of the recommendations. The bureau has suggested a series of international health information campaigns to be directed towards smokers, teachers, doctors, and parents.

It has also called for a ban on cigarette vending machines, and on the sale of cut-price cigarettes to soldiers. It wants strict new measures to enforce the existing bans on the sale of cigarettes to minors. And it calls for smoke-free areas in most public places such as aircraft, restaurants, and hotels, and a complete ban on smoking in places like doctors' waiting rooms, museums, and buses.

Some member countries have already gone well beyond these recommendations. Italy, for example, passed legislation in 1976 totally banning the use of tobacco in most public places. Tobacco advertising has been banned there since 1962.

But Britain is still the only member of the Community to require tobacco companies to mark clearly the tar content of cigarettes on their packages.



Britain is the only member of the European Economic Community which requires health hazards of tobacco be inscribed on cigarette packs. Photo (above): Scottish Health Education Unit.

Drinking patterns are set by grade 10

By Manfred Jager

WINNIPEG — Future drinking habits of young people are decided by and large, by the time they leave grade 10, according to an Alcoholism Foundation of Manitoba survey of six Portage La Prairie schools.

Said the survey report:

"By grade 12 there were almost as many light, normal, and heavy drinkers as we would find in the same number of adults.

"These findings indicate that by grade 10 most students have decided whether they will join the adult drinking population. By grade 12 the pattern of their adult drinking appears to be set."

By far, most students — 78.3% — said they had used alcohol at least once in the last 12 months, including about 88% of those in high school classes.

While the survey revealed heavy involvement with alcohol among the students, it failed to uncover rampant excess drinking.

Results showed more than half the students drink less than once a week, and consumption per student is less than four drinks on any given occasion.

At the same time, the AFM survey discovered 15% of grade 12 students average two to five drinks a day, compared with 9.5% of grade 11 students, and 7.7% of grade 10 students.

The report said a study of Manitoba adults this year found 16% average two to five drinks a day.

R. S. Graham, chairman and managing director of the AFM, said the results did not surprise foundation officials. They merely bore out indications Manitoba junior and high school students drink about the same amount of alcohol as those elsewhere.

The survey report said a similar study undertaken in Ontario during 1974 found about 75% of students in grades seven, 9, 11, and 13 had used alcohol during the previous year. A recent California study for the same grades said 85% drank alcoholic beverages.

The report cautioned that studies have shown some heavy drinkers under-report their consumption, and drinkers younger than 18 may over-report.

Statistical evaluation of the findings indicates there is virtual equality between the sexes. As many girls as boys said they had used alcohol in the previous year, and more girls than boys said they smoke.

Of all respondents to the survey, 43.9% said they smoke.

"The trend toward the increased use of alcohol and other drugs by women has been noted in other studies," the report said. "This is the first time in Manitoba that parity has been documented."

Thirty-five per cent of the students said they had used marijuana during the past year. Questions about frequency or regularity of marijuana use had not been included in the questionnaries.

The foundation has also surveyed students in Dauphin and Beausejour, and plans to undertake similar projects in Winnipeg, Brandon, and Thompson in the near future.

Mr Graham said the results obtained in Dauphin and Beausejour are about the same as those in Portage la Prairie. No significant variation is expected to be found when Winnipeg results are in.

He said there is nothing new in a survey showing teenagers drink. However, there is cause for concern at the increasing use of alcohol.

The report said the finding on students' drinking patterns being established by the time they reach high school supports the arguments for a need of early intervention and prevention.

Women criticize NB agency hirings

FREDERICTON — Controversy continues to swirl around the New Brunswick Alcohol and Drug Dependency Commission, with recent appointments coming under fire from the province's government-appointed Advisory Council on the Status of Women.

The appointment in March of Everett Chalmers to the chairmanship of the ADDC led to criticism from both the province's Francophones and from Madeleine LeBlanc, chairman of the Status of Women Council.

Dr Chalmers resigned from the Hatfield cabinet and his Fredericton Legislature seat, and retired from his medical practice in early September to take over his ADDC duties on a full-time basis.

The same day, Premier Richard Hatfield announced the appointments of eight men and two women to the ADDC.

The day following the Premier's announcement of the appointments, the Advisory Council on the Status of Women issued a news release in which it was charged the appointments showed a lack of sensitivity to the problems of women in terms of alcoholism and drug abuse.

In keeping with its May declaration that it will insist on a 50% representation on the ADDC, the Status of Women Council said it still recommended equal representation of men and women.

The Council, the release said, had provided the Premier with a list of qualified women and had been promised "full consideration" of the nominees by Mr Hatfield, yet none had been appointed to the ADDC.

The Council charged the government has ignored the problems of women. It claimed there were as many women alcoholics in New Brunswick as men alcoholics, while women were given prescriptions for twice as many tranquillizers, barbiturates, and sedatives as men.

In addition, fewer beds have been assigned to women in the province's detoxification and rehabilitation centres.

In its May statement, the Status of Women Council had demanded not only equal female representation on the ADDC, but also "a professionally-qualified woman coordinator ... to oversee the implementation of treatment programs and services for women alcoholics and drug addicts. This coordinator will keep the NB Advisory Council informed as to the activities and programs of the Commission."

NZ planning long term drug curriculum



New Zealand schools may use illustrations such as the one above, taken from the book of short stories The Hole in the Fence. The book was developed by Canada's federal Promotion and Prevention Directorate, for their own drug education curriculum.

WELLINGTON, NZ — A cautious New Zealand bureaucracy is moving gradually toward adopting a Canadian model of drug education, based partially on a book of short stories, *The Hole in the Fence* (**The Journal**, September, 1975).

But it will be at least the mid-1980s before a firm decision is made on which drug education course to introduce as part of an integrated curriculum on social and health education now in preparation.

Interest in drug education in schools here began in the mid-1960s, reflecting community concern about sharp increase in illicit use of drugs such as marijuana, heroin, and LSD by young people.

A report to government last year by a committee on health and social education concluded that some of the current information-based drug education programs were in fact counter-productive.

And recent surveys testing these programs' effectiveness have revealed that information-only courses can add to the drug problem. Material showing the dangers of taking drugs can in fact excite pupils and encourage possibly hazardous experimentation, the surveys claimed.

In response to the government committee's recommendations, and increased pressure from police and health authorities, the government recently unveiled plans for a two-pronged attack covering both long and short term measures against drug abuse.

In the short term, parliament is about to debate tough punitive legislation aimed at curbing drug trafficking (**The Journal**, October).

The government also has just approved a five-year pilot project to be undertaken by the education department, aiming to develop a comprehensive preventive curriculum about drugs, including alcohol and tobacco.

The Hole in the Fence revolves around the doings of 20 characters, all of them vegetables. Mr Mushroom, the most important character, enters the garden world through the hole in the fence, bringing with him tales of greener pastures and a "Magic Potion." The stories focus on things like cheating, lying, stealing, revenge, and 'magical solutions' to problems. The idea is to let children (as young as six to nine years) see for themselves the long term pitfalls of these things, the value of friendship and justice, and the fact everyone has weaknesses and strengths. Of course, there are not so veiled lessons about drugs; how to use medicines properly, and how 'magic solutions' are not 'real' solutions to problems.

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Ennals hits UK smoking

LONDON — Britain's health and social services secretary David Ennals has revealed again his personal commitment to non smoking as a step towards improving the nation's health.

He took the unusual step of congratulating personally a hospital, the Central Middlesex Hospital, Brent, for proposing a "smoking action week" where staff will be urged to quit the habit. Mr Ennals further suggested the initiative should be taken up by factories, cinemas, and other institutions.

Around the World

Down under

The Australian department of health has estimated that 11,000 deaths in the country each year are due to cigarette smoking. The Heart Foundation believes that if all deaths over the age of 65 are excluded, cigarettes are responsible for 6,000 premature deaths in Australia annually. More than half (52%) of premature deaths occurring among smokers, are from heart and blood-vessel diseases.

Soviet Efforts

In some Soviet cities, the message to quit smoking is becoming more obvious. Instructions calculated to induce relaxation, followed by subliminal non smoking messages and soothing music are among some popular methods. Citizens who complete a smoking cessation program receive a certificate of merit, and are contacted periodically to help them maintain their non smoking lifestyle.

Women's Offences

Involvement of women in drug offences in New Zealand is increasing. Last year there were 190 convictions of women on drug charges compared with only two in 1967.

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GUIDES

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A 36 page handbook on alcoholism developed for the primary care physician in conjunction with the Ontario Medical Association. A "how-to" guide dealing with identification, diagnosis, short and long-term management in both the medical and psycho-social senses. Invaluable to the medical practitioner.

P-160 **TEN LESSON PLANS FOR GRADES 7 AND 8** **$7.95**
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The program consists of two sets of 10 lesson plans. Each lesson deals with a separate topic and can be used independently. Developed in conjunction with the Toronto Board of Education. The lesson plans provide the teacher with as much information concerning alcohol and the process of teaching about alcohol as is possible. Includes suggestions for A/V and other materials to enhance the program. The Ontario Ministry of Education has reviewed the lesson plans and found them to fit Ministry guidelines.



BOOK

A SYSTEMS APPROACH TO ALCOHOL TREATMENT

Authors: Frederick B. Glaser, M.D.
Stephanie W. Greenberg, M.A.
Morris Barrett, M.P.H.
$14.95

A major work which provides the results and conclusions on the system of alcoholism treatment programs within a large geographic area. The book provides a factual base from which to proceed toward developing a systematic alcoholism service delivery program. Will be of interest to administrators, organizational and policy personnel, and the general health care professional.



VIDEO CASSETTE

V-028 **MARIJUANA - THE FACTS** **$95.00**
25 Minutes, Color

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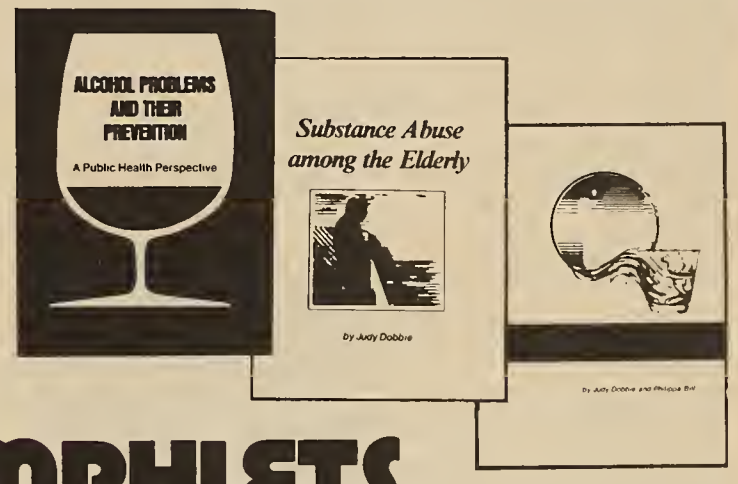
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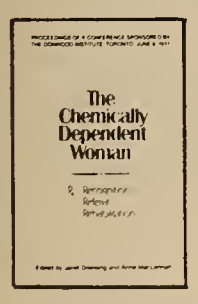
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Would use be beneficial for particular medical problems?

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Proceedings of a two-day international seminar marking the designation of the Addiction Research Foundation as a collaborating centre of the World Health Organization.

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New Books

by RON HALL

The Alcoholic Woman's Mad, Mad World of Denial and Mind Games

. . . by Bonnie-Jean Kimball

The author maintains that although denial of alcoholism or drug dependency is a characteristic symptom of the illness for both men and women, the process has a subtle and devastating difference for women. The intention of the book is to show the part that denial plays in all areas of drug dependence, and to illuminate some of the dimensions of denial. A discussion of the definition of alcoholism, and the differences between psychic and physical dependence is followed by a series of scenarios depicting the role of the spouse, the doctor who prescribes medication, and the clergyman who suggest family counselling as resolutions to the problem. Women frequently delay seeking help in order to avoid societal pressures and the denial is made easier through protection offered by family, friends, and other members of society who attempt to minimize the problem. Mind games are discussed and advice is offered for those who are interested in helping through understanding abstinence and effective intervention. The importance of spiritual change and the role of Alcoholics Anonymous are noted.

(Hazleden Books, Box 176, Center City, MN, 55012. 1978. 73p. $3.50).

Other Books

Controlling The Use Of Therapeutic Drugs: An International Comparison — Wardell, W. M. (ed). American Enterprise Institute for Public Policy Research, Washington, 1978. North America, Western Europe and the Commonwealth, and Eastern European system. 263p. $4.75.

A Systems Approach To Alcohol Treatment — Glaser, F. B., Greenberg, S. W, Barrett, M. Addiction Research Foundation, Toronto, 1978. Based on a study done in Pennsylvania, USA in 1973. Identified existing elements of the system — treatment programs, other intervention efforts, recommendations, appendices, tables, program director, relevant legislation, government policy, references. 303p. $14.95.

Sociology Of Deviant Behavior — Clinard, M. B. Holt, Rinehart and Winston Inc, Toronto, 1974. Urbanization and slums, criminal behavior, law, police and prisons, drug use and addictions, drunkenness and alcoholism, mental disorders, suicide. Index, references. 685p. $12.95.

A Socio-Demographic Profile Of People Prescribed Mood-Modifiers In Saskatchewan. Final report — January 1978 — Harding, James. Alcoholism Commission of Saskatchewan, Regina, 1978. CNS prescribing trends, profiling by age groups, methodology and applications of the study. Bibliography, appendices. 80p.

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six point scale. For further information, contact Linda Chung, coordinator of the group at (416) 595-6150.

Alcohol, Drugs . . . "The First Step" A Way Out

Subject Heading: Alcohol and alcoholism overview, attitudes and values.

Details: 20 minutes, 16 mm, color, sound.

Synopsis: Narrator Cameron Mitchell asks "Looking for a way to make alcohol and drugs work for you? If you are, then this film is for you." People who depend on temporary crutches to survive are in trouble. Two people discuss why they use alcohol; because of their job, their home life, and dozens of other environmental elements. It seems that problems multiply problems. The first step in finding "a way out" is to stop making excuses and face the problem. A section in the film called the "Winner's Game" presents an approach to change our lives and head towards more meaningful and constructive new directions.

General Evaluation: Good (4.0). A contemporary and informative film with high technical quality, this film was deemed an effective teaching aid. The A/V Group liked what the film said about drug use, and felt it could produce attitudes opposed to drug use and help in decision making regarding drug use.

Recommended Use: Likely to benefit audiences of 15 years of age and older. Presence of a resource person is recommended but not essential.

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Canada

Workshop On Dependency, A Disease, Illness Or Behaviour — Nov 23, 1978, Toronto, Ontario. Information: Mr F. Fallon, Addiction Research Foundation, 33 Russell St, Toronto, Ontario, M5S 2S1.

Detox Training Program — Nov 27-Dec 1, 1978, Feb 5-9, March 26-30, April 30-May 4, 1979, Toronto, Ontario. Information: Mr G. Gooding, Assistant to the Coordinator, Detox and Rehab Programs, Addiction Research Foundation, 33 Russell St, Toronto, Ont. M5S 2S1.

70th Annual Conference Of The Canadian Public Health Association — June 18-22, 1979, Winnipeg, Manitoba. Information: Mr G. H. Dafoe, Executive Director, CPHA, 1335 Carling, Suite 210, Ottawa, Ontario, K1Z 8N8.

United States

Family Service Association Of America North American Symposium On Family Practice — Nov 1-4, 1978, New York City. Information: FSAA, 44 East 23rd St, New York, NY, 10010.

National Conference On Medical Education In Alcohol And Drug Abuse — Nov 16-17, 1978, Washington, DC. Information: Dr Charles Buchwald, Conference Coordinator, Career Teacher Center, Downstate Medical Center, 450 Clarkson Ave, Box 32, Brooklyn, New York, 11203.

Alcoholism Professionals Of North Carolina, Fall Meeting — Nov 16-18, 1978, Wrightsville Beach, NC. Information: Margaret Davis, Southeastern Mental Health Center, 2023 South 17 Street, Wilmington, NC, 28401.

New York State Association For Human Services — Nov 20-21, 1978, New York City. Information: Family Service Association of America, 44 East 23rd St, New York, NY, 10010.

3rd Southeastern Conference On Alcohol And Drug Addiction — Nov 29-Dec 3, 1978, Atlanta, Georgia. Information: Conway Hunter Jr, Medical Director, Addictive Disease Unit, Peachford Hospital, 2151 Peachford Rd, Atlanta, Ga.

National Organization For The Reform Of Marijuana Laws 7th Annual Conference — Dec 1-3, 1978, Washington, DC. Information: NORML, 2317 M St, NW, Washington, DC, 20037.

First National "Women In Crisis" Conference — May 17-19, 1979, New York City. Information: Jane Velez, Conference Administrator, "Women in Crisis", 444 Park Avenue South, New York, NY, 10016.

Abroad

International Conference On Animal Models In Alcohol Research — June 4-7, 1979, Helsinki, Finland. Information: John David Sinclair, Research Laboratories of the State Alcohol Monopoly (Alko), Box 350, SF-00101 Helsinki 10, Finland.

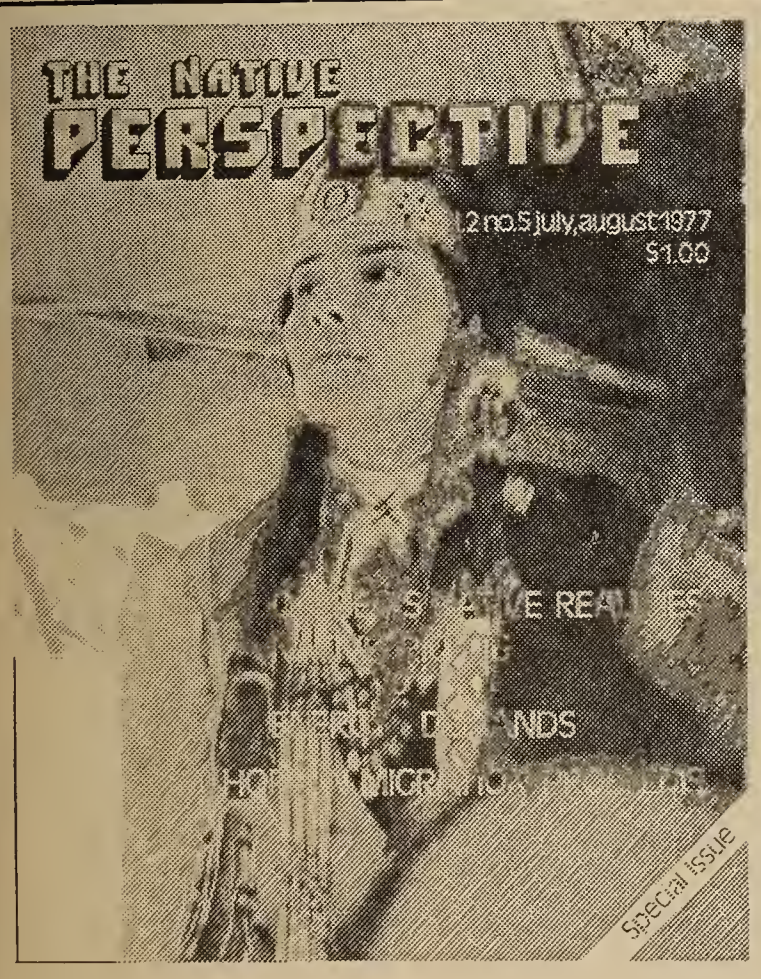
25th International Institute On The Prevention And Treatment Of Alcoholism — June 18-22, 1979, Tours, France. Information: International Council on Alcohol and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

10th International Conference On Health Education — Sept 2-7, 1979, London, England. Information: The Conference Centre, 43 Charles Street, Mayfair, London W1X 7PB, England.

Third World Congress Of The International Commission For The Prevention Of Alcoholism And Drug Dependency — Aug 26-31, 1979, Acapulco, Mexico. Information: ICAP Executive Director, 6830 Laurel Street, NW, Washington, DC, 20012.

International Conference On Alcoholism And Drug Dependence — Sept 3-7, 1979, Tegucigalpa, Honduras. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

26th International Institute On The Prevention And Treatment Of Alcoholism And International Institute On The Prevention And Treatment Of Drug Dependence — June, 1980, Cardiff, Wales. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.



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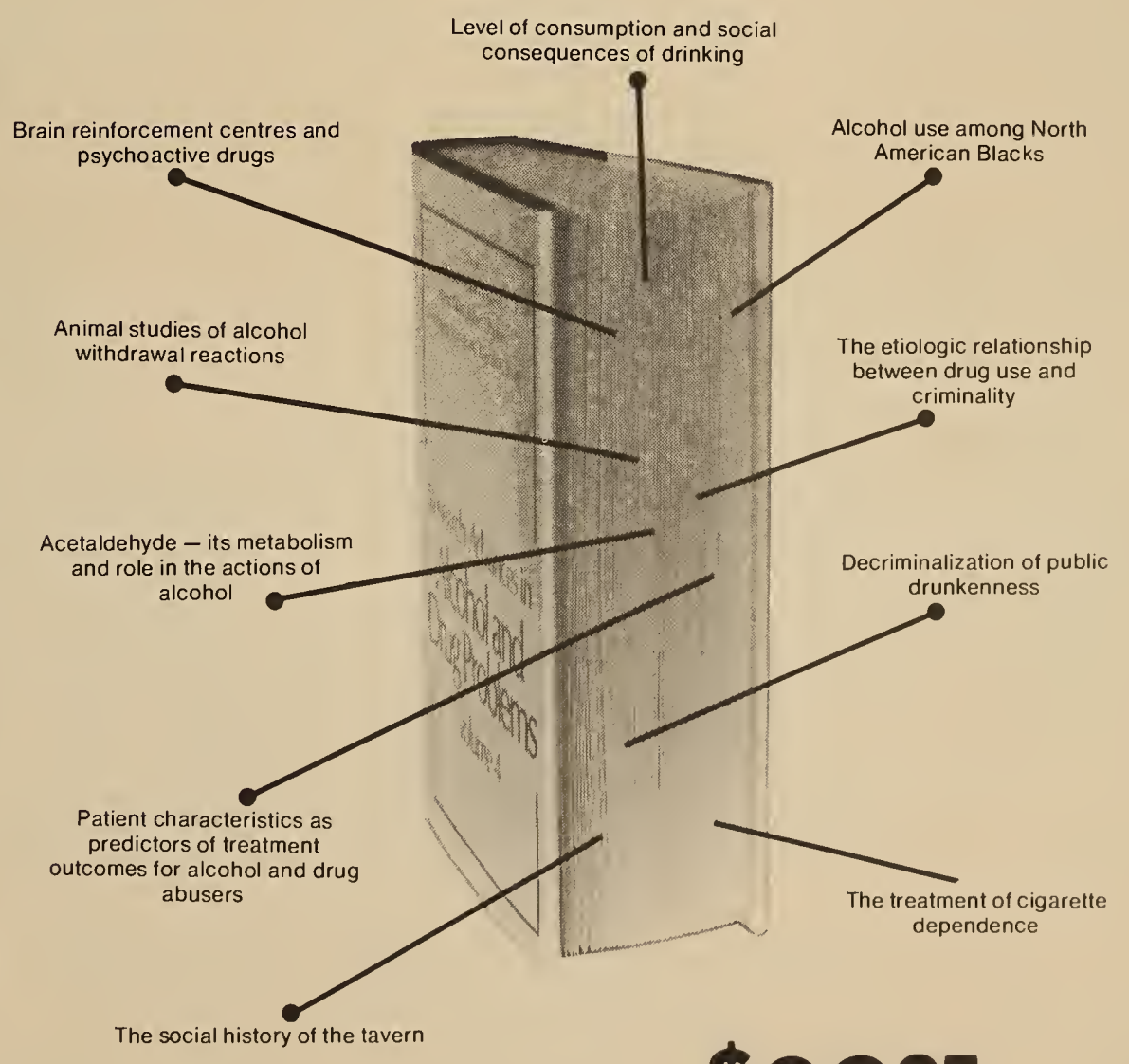
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Chopin, war memories, vodka still mix on Poland's streets



Anne MacLennan reports from Warsaw.

WARSAW — The music and memory of Chopin, World War II, the stark intensity of the work of the country's revered poster artists.

And vodka.

They're four powerful, perhaps entangled, constants in the Catholic and Communist Poland which has given the world Pope John Paul II.

Poster art and vodka are almost cults — not necessarily for different reasons, suggests one writer.

Chopin and the war remain living memories. Chopin was born near Warsaw and died many years ago. But his music and name still permeate the culture.

During the war, Chopin's music was played at risk of death. Monuments and plaques were destroyed. He would be erased from the Polish consciousness. That was the Nazi order.

But, in small, secret rooms, the music was given new life, firing resistance workers with courage and strength, and evolving into today's bittersweet reminder for Poles of home and the war.

It's three o'clock on a Warsaw afternoon in September. In a small meeting room nearby, someone — a visitor, a staff member — plays a Chopin polonaise on one of several available pianos.

The music forms the background to a Polish psychiatrist's recollections of war. She was a teenager when Warsaw was under seige.

In those years between 1939 and 45, says a guidebook, 800,000 people in Warsaw lost their lives and most of the city was destroyed, including 75% of school buildings.

This psychiatrist's school was one. She finished high school "underground" and saw friends who were caught, shot in the streets.

After the war, she was ready for university. With others, she went to the rubble that had been the medical school, found and cleaned the bricks, and started rebuilding. The intensive reconstruction of Warsaw was under way.

Added during this reconstruction was what is by far the most prominent feature of the Warsaw skyline — the Palace of Culture and Science. It's the venue of this 32nd International Congress on Alcoholism and Drug Dependence.

A congress organizer explains that Warsaw hosted the 21st congress as well but almost no records remain. The conference was in 1937 and proceedings were printed just before the outbreak of war. Almost all copies were burned in the seizure of the city.

John Zylinski is a Pole, born in London, England, and a poster collector. He sees posters as the "dream factories" of the Polish people and suggests the popularity of both the posters and alcohol may be indicator's of the nation's frustration.

"Basically, it (poster art) is a desperate desire to communicate, to hijack our emotions as we walk down the street, to play a role in our daily life."

He suggests the posters' power at the subconscious level says a lot about Poland.

"Polish people are really underground people. The opposite may seem to be true because individually they are often very flamboyant or, in 1939, they make cavalry charges against German panzers."

On the other hand, he says, between 1795 and 1918, Poland did not exist as a state and the only form of true national expression was through the arts. Tsarist censorship forced posterists to camouflage their intentions with the aid of an underground language of symbolism and association.

"In their hearts, Polish people remained underground even after 1918 when Poland regained her independence. You can see the frustration in the endless violence that litters these posters," he says.

The high rate of alcohol consumption may be an indicator of the same thing, he adds.

If it is, then in terms of overall alcohol consumption, Poland is in the company of most other developed countries and no more or less frustrated.

Ignacy Wald is a vice-chairman of the Polish organizing committee of this congress and chairman of the expert advisory committee to the permanent commission on alcoholism of the council of ministers of Poland. He is also head of genetics, and research director, at the Psychoneurological Institute in Warsaw.

"I wouldn't say consumption, compared to other countries, is very big. It's average. We're around 18th on the list of general mean consumption. We've had a rather quick increase in consumption but we're around fourth in the rate of increase."

He refers to figures over the years since 1938 when consumption was 1.5 litres per year per capita, to 1950 when it was three litres; and 1977 when it had risen to 8.2 litres.

What influences might the political system have? "These problems, especially of alcohol, are ubiquitous," he says. "They are not dependent on social systems. There is no automatic dependence in one system and not in another."

THE BACK PAGE

What does plague the Poles is the structure and pattern of consumption or, vodka and how it's drunk.

Their approach to vodka has been called "suicidal," "heroic." Whichever, coupled with its constantly increasing consumption from 1962 onwards, it presents serious problems.

Dr Wald explains: "Seventy per cent of our consumption goes in the form of distilled liquors. In this country, distilled liquor means vodka and, in terms of distilled liquor, Poland holds first place in the world.

"It's customary in Poland to drink vodka straight and to drink in order to be drunk. It's machismo," he says.

A government paper enlarges: "The consumption of alcohol is spread out very evenly. The number of possible consumers is estimated at about 19 million people . . .

"About two million of these belong to the so-called group of 'intensive' drinkers; they consume about one half of all alcoholic drinks sold." (About 7% are women, the rest are professionally active men).

"This means that every fifth professionally active man is addicted to alcohol. Each 'intensive' drinker consumes an average of . . . 368 grams (13 ounces) of ordinary vodka daily.

"Of these two million, about 500,000 require medical treatment and at least 100,000 are incurable or people with very serious health problems arising from alcohol addiction."

Dr Wald: "Everyone here feels this structure of consumption is unhealthy. The type of beverage used is very important in terms of behavioral changes."

Another chief concern, and one echoed around the world, is increasing drinking among young people with a shifting age of onset to younger ages, even younger than 14 or 15 years, says Dr Wald.

While vodka accounts for 70% of alcohol consumption, beer and wine account for about 15% each. Since the war, cheap fruit wine has become more popular with young people.

However, fruit wine or no, young people, particularly young men, quickly learn the 'heroic' drinking patterns of their elders.

They begin — at least boys do, the figures are less clear on girls — at age 14 or 15 years with beer, move quickly to wine, and then to vodka. An estimated 55% of boys at secondary schools drink vodka and from age 20 on, it's the favorite drink.

"In fact, young people from 18 to 20 consume as much as their elders, says one government paper.

Dr Wald suggests two main reasons for the rising consumption in Poland — increased economic availability and increased access.

"We have witnessed in the last eight years, a rather rapid increase in personal income. The price of vodka was raised in these last eight years two times, in 1974 and in 1978.

"But, if you take the 1974 increase only . . . the relative price has decreased by 36% in relation to personal income.

"In 1978, there was another increase in the price and we don't know yet what's happened. The increase was biggest on vodka so this is aimed at reducing vodka consumption."

Also, he says, there is an "unduly big network of distribution."

"There is one point of alcohol selling for something like every 1,000 population. So, it is 10 times more than in Finland or Sweden. You can buy beer and wine in many grocery stores and, in some, even vodka."

Pragmatic concern doesn't appear to end with congress participants or those directly involved with the alcohol and drug field.

During the congress, a small, selected group of people is invited to meet with President Henryk Jablonski, titular head of state, chairman of the council of State for Poland.

Of the group, a few are invited to comment briefly on problems and developments in their own countries. One is H. David Archibald, executive vice-chairman of the Addiction Research Foundation in Toronto.

"The president was an impressive man, both in personality and in knowledge," says Mr Archibald.

"Prior to entering political life, he was apparently a professor of history at a major university. He was well briefed and referred, among other things, to research carried out by the Addiction Research Foundation."

Mr Archibald continues: "The president stressed there was no drug abuse problem in Poland, presumably because of the effective legal control measures and well-developed public education program. However, alcohol was quite a different matter and the cultural heritage in Poland was an important factor in an individual's attitudes to, and use of, alcohol.

"This heritage includes the tendency to consume vodka throughout the day, plus at meals, where vodka is the first item served, and is drunk 'neat' and in one gulp."

The president also noted that Polish data indicate per capita consumption of alcohol is not as large as in a number of other countries, but "the problem of alcoholism apparently was larger than in some other countries where consumption was higher. He posed this as a dilemma," says Mr Archibald.

Treatment of alcoholics in Poland dates from the period between the two World Wars but real development began in the late 1950s when the first of two new acts on alcohol came into effect, the first in 1956, the second in 1959.

Medical and social care are free and treatment is generally voluntary. However, alcoholics who do not report for treatment and whose drinking is judged as seriously disrupting to family life, "demoralizing to juveniles, or a danger to society" are compulsorily treated in dispensaries or hospitals. This is according to the 1959 Alcohol Act, says Dr Wald.

Treatment consists mainly of psychotherapy and sociotherapy. Pharmacological treatment is used only to complement these.

(There were, in 1977, 434 alcohol clinics delivering medical care to 125.5 thousand patients, 36,000 of whom were registered for the first time. There are 39 Alcoholics Anonymous clubs cooperating with alcohol clinics; 45 wards mainly at mental hospitals; and nine specialized institutions for alcohol treatment, and with nearly 3,500 beds. About 14,000 people were hospitalized for alcoholism in 1977.)

Celina Godwod-Sikorska (Godwod is a contraction of Goodwood — her husband is a Pole but his ancestors were Scots) is the psychiatrist who helped build the medical school from which she graduated.

Today, she heads the department of studies on alcohol and drug dependence at the Psychoneurological Institute in Warsaw. She is also secretary to the expert advisory committee to the permanent commission on alcoholism of the council of ministers of Poland.

Young people and families, especially the children of alcoholics, are among her chief interests.

"The people at great risk," she says, "are the children of alcoholics."

She and colleagues did a 10 year study of two sets of children — one group of 100 from 37 families with one alcoholic parent, and a matched control group of 50 children from 21 non-alcoholic families. They were all two-parent families.

The study began in 1966-67 when the children ranged in age from six to 18 years. The children and parents were seen again in 1976-77 when the children were aged 16 to 28. The results were "dramatic" as Dr Godwod-Sikorska says.



Celina Godwod-Sikorska (left), and Ignacy Wald, experts on Polish alcohol problems.

In the alcoholic families, at 10 years, 69% of the parents were divorced or separated; 71% reported fighting and a "bad" life; and 11% reported a "good" life. Children and parents were interviewed separately.

In the control group, only 12% of parents had split, none reported fighting or a 'bad life,' and 61% reported a good life.

Nearly half of the children of alcoholic families completed their schooling at the elementary level. Another 20% completed a technical school course (after elementary school); 22% completed high school; and 10% university.

Of the controls, however, only 31% completed schooling at elementary level. Ten per cent finished technical school; 46% finished high school; and 13% university.

The children from alcoholic homes seemed to "want to get away" more quickly, says Dr Godwod-Sikorska. The control children, meanwhile, tended to remain in school. Twenty of the children of alcoholic families (18%) had lost jobs through drinking.

Most of the young people in both groups got drunk for the first time after they were 15 years old. However, the majority of control children (75%) had been drunk only once in the last year as compared to only 25% of the other children. And 37% of the study group had been drunk more than three times in the last year whereas none of the control group had been.

Drugs? Although there was a short burst of activity in the 60s, says Dr Godwod Sikorska, total admissions for treatment of drug use or abuse have never numbered more than 1,000 in a year.

"The problem isn't developed really. It's very unpopular in Poland to take drugs."

Frustration, heroics, suicide, or dream factories. It's vodka that helps Poles. And hurts.

Illustration: From Stanislaw Pudelko's poster commissioned for the 32nd International Congress on Alcoholism and Drug Dependence, Warsaw.

Vol. 7 No. 12 2nd Class Mail Reg No. 2776

TORONTO December 1, 1978

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

Paraquat poisons opium strategy

By Harvey McConnell

MEXICO CITY — The Mexican government has made it clear it is prepared to stop eradication of the opium poppy if United States bilateral aid is withdrawn because the herbicide paraquat is being used to spray marijuana crops.

This would be a severe blow for the United States. The poppy eradication program in Mexico is linked directly by US authorities to the reduced estimates of heroin addicts in the US, and low purity and high prices on the streets (see page 12).

Drastic action is not imminent. An amendment which came into force in October to stop American aid for use of herbicides which could be harmful to human health, is so phrased that it could be 18 to 24 months before any final action.

Mexican officials, in a show of solidarity, do not wish to be quoted publicly. In private, they leave no doubt they mean what they say.

A long-time observer points out that any attempt to bow to such pressure by the United States would be politically impossible for President Lopez Portillo.

Mexican officials are alarmed by the growing use of marijuana among Mexican young people and are determined to use every means possible to curb it. Spraying with paraquat is the most effective method yet found to cut down supplies.

At the same time, they point out that heroin addiction, except for some cases in towns along the US-Mexican border, is almost unknown. The poppy eradication program is doing a good friend and neighbor a favor.

The US supplies technical assistance in the form of helicopters. The paraquat, patented by Imperial Chemical Industries in Britain, is manufactured in Mexico.

And most important of all now to the United States, are the public disclosures over the past few months that Mexico may have oil reserves almost twice as great as those in Saudi Arabia, the main supplier of oil to the US.

The use of the herbicide 2-4-D on the poppy, and paraquat on marijuana, is a year-round operation, shifting through climatic zones across the country.

There is no question the poppy eradication campaign has been successful. Flourishing two- to three-hectare fields have disappeared. Small poppy plots are now being discovered under cliff tops and trees as farmers try to hide cultivation from aerial surveys.

In the town of Culican, centre of the trafficking trade, the flow of money in and out of local banks has diminished. Even the murder rate in the town, known for its lawlessness, has dropped. And in the growing fields themselves fewer empty beer cans litter the ground.

The farmer in many cases does not lose: even if his crop is destroyed in advance by the trafficker, he has been paid to grow opium poppies instead of either marijuana or nothing at all.

Mexico's determination to do what it thinks best for its own interests is unquestioned.

(See — Detente — Page 2)

OK to bug confessional in new law

By Pat McCarthy

WELLINGTON, NZ — Electronic bugging of a priest's confessional, a doctor's surgery, or a lawyer's office is a controversial possibility under tougher legislation intended to combat New Zealand's hard drug traffic.

Use of listening devices, tracking devices, and telephone tapping will be permitted against suspected drug dealers. Each interception by police will require a warrant from a Supreme Court judge.

In the case of the home or business premises of a lawyer, doctor, or clergyman, a judge may prescribe conditions "to avoid so far as practicable the interception of communications of a professional character."

Among critics of the provision, a Catholic bishop said his priests would be told to destroy any bugging device they found in a confessional. However, he later said his mind had been set at rest by a government assurance that police would be permitted to bug the conversations of a clergyman only if a judge was satisfied he could be involved in drug offences.

Evidence gained through bugging a confessional would in any case not be admissible in court.

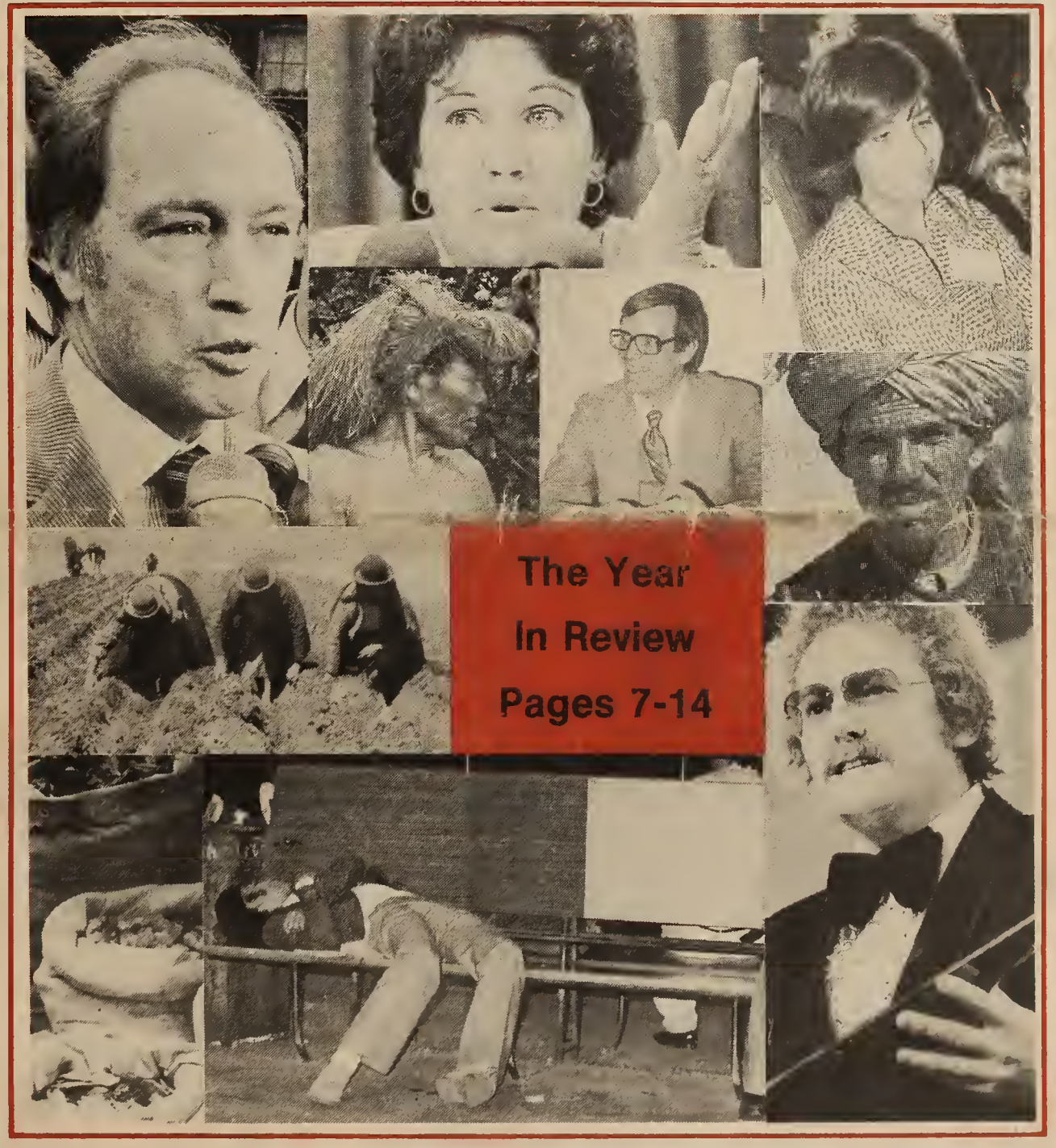
The new legislation will cover such drugs as LSD, heroin, cocaine, opium, morphine, and cannabis resin, but not marijuana.

Maximum penalties for trafficking are life imprisonment or a fine of $15,000. Bail and parole provisions are tightened up.

A court may also impose an increased fine if it is satisfied that assets or money owned by a convicted offender at the time of trial were acquired from drug-dealing.

The new legislation will bring New Zealand into line, in most respects, with Australian law. Earlier this year, the customs ministers of the two countries discussed harmonizing their laws so drug dealers could not take advantage of lesser penalties in one country.

See — Backgrounder — page 2)



Problems thwart BC's heroin plan

By Tim Padmore

VANCOUVER — Problems piled up this fall for British Columbia's compulsory heroin treatment program.

Parts of the program have been delayed up to three months because of administrative and legal tangles. A doctors' revolt is brewing and the first legal challenge to the legislation's constitutionality has been filed.

While 11 outpatient clinics are expected to be ready to go by the Jan 1 starting date, the 150-bed detention centre for recalcitrant addicts at Brannan Lake on Vancouver Island is not expected to be ready until February.

Also, the program will not be able to handle police referrals until April 1. Lack of trained staff and a tangle of "legalities" have been cited as reasons for the delay.

Another problem is the failure of the federal Liberal government to get Bill C51 on reform of the Criminal Code passed in the last session.

At press time, the British Columbia Medical Association's board of directors had reaffirmed their earlier resolution supporting BC's compulsory treatment plan for heroin addicts, following a move by Health Minister Bob McClelland to stifle the doctors' opposition to the plan. The minister promised doctors the BC government would reimburse them for the cost of any malpractice actions brought against them as a result of duties performed under the heroin legislation.

The Bill allows the court to direct people accused of an offence, into a treatment program such as the BC plan. This is expected to be a major source of clients.

But Bill C51 died on the order paper last session. It will likely be re-introduced, but no action was expected on it until after Christmas.

The province's doctors, one of the few groups to endorse the plan officially when it was proposed, are increasingly convinced it will not work, and they are worried that any doctors who participate in it will be liable to charges of assault and battery, and heavy civil damages.

Seriously proposed are:

- A boycott of the program unless the government offers financial guarantees against possible legal action.
- A declaration that Bill 18, the Alcoholism Treatment Act, is criminal legislation, not health legislation (and therefore outside provincial jurisdiction.)

(See — Civil — page 2)

British Columbia's alcohol blues

The Back Page

Case closed on secret drug files-they're open

By Jeff Carruthers

OTTAWA — The "secret drug files" in Ottawa are no longer totally secret.

Partly as a result of an investigation by **The Journal** that publicized the existence of the files, the federal bureau of dangerous drugs must now, on request, tell an individual whether he or she has a file among the more than 309,000 the bureau has been quietly accumulating for more than a decade. The files are on known or suspected users of cannabis, illegal narcotics and, in more recent years, illegal hallucinogenics.

A person who is one of the known or suspected drug users in Canada, now has the right to request to see the contents of the file, under the privacy provisions of the Human Rights Act.

(The same legislation will allow the government to delete information on third parties in the file, along with other information that might endanger national security or interfere with ongoing police investigations.)

The change in the status of drug files took place on November 15, when the federal cabinet withdrew an earlier cabinet order allowing the federal bureau of dangerous drugs to keep the files completely secret.

Until then, the secrecy was so total the bureau wouldn't even admit whether a file existed on any particular individual.

Federal Health and Welfare Minister Monique Begin had promised more than four-and-one-half months ago to reverse what she admitted at the time was a questionable secrecy order.

She had said the necessary changes would be accomplished by mid-August at the latest; but the political uncertainty about a fall election, the summer recess for cabinet committees, and some continued complaints from police forces delayed final resolution until November.

In opening up the files and retaining the right to delete sensitive information, Ms Begin said she has the "simple conviction that a more direct ministerial control and a case by case review (where warranted) of what information should not be released is the best way to protect individual rights."

In effect, Ms Begin believes an elected politician is more responsive to individual needs than bureaucrats — an interesting conviction, since the Minister took one month to decide to reverse what the department's bureaucrats took six months claiming could not be changed.

The final move by the government comes despite vigorous protests by some of the police forces (including the Metro police forces in Vancouver and Toronto) that expressed concern that opening the files could jeopardize some of their sources of information on drug crimes.

While some of the information contained in the drug files comes from doctors, drug treatment centres, pharmacy reports, and even complaints from neighbors, the bulk of it comes from police reports.

Just as bureaucracy originally claimed that openness was not possible, and later dragged out the process of removing the secrecy over almost six months, bureaucracy might now delay the release of individual drugs files to named individuals, so they can check the accuracy of the information in the files.

The health department, which now will have to process and review requests for access to individual drug files, has just been hit hard by manpower cuts resulting from the fiscal restraint policy of the Liberal government.

And the Human Rights Commission, which handles complaints about bureaucratic delays or even refusals to provide information from files and data banks, also has been hurt, like many other government agencies, by federal fiscal restraint. Backlogs are already developing in some areas, because of shortages of staff.

Individuals interested in gaining access to their files must fill out a record access request form available at any post office, requesting information on Data Bank 14086, "Drug Investigation (Users and Distributors) Files." The file must then be sent to the Director, Bureau of Dangerous Drugs, Department of National Health and Welfare, Room 322, Tower "B", Place Vanier, 355 River Road, Ottawa, Ont, K1A 1B8.

Civil liberties group challenges validity of BC plan

(from page 1)

• Reversal of the BC Medical Association's earlier endorsement of the plan.

Both the College of Physicians and Surgeons of BC and the BC Medical Association are debating these questions.

Ken Varnam, chairman of the BCMA's drug and alcohol committee, said in an interview, his committee "cannot really accept that (the plan) is the way to go."

Experience with similar drug treatment plans in California, and at Matsqui in BC suggests the plan will fail, he said.

Beyond that is the danger that physicians examining or treating an unwilling "addict" might be judged guilty of assault.

"Until there is a court challenge and until it is decided, I, and most physicians, would not be prepared to do anything we would not be allowed to do in our ordinary practice," Dr Varnam said.

Dr J. A. Hutchison, registrar of the College of Physicians and Surgeons, said he feels the province should agree to pay any legal costs and damages before doctors agree to diagnose and treat addicts.

A boycott would cripple the plan, since the law requires two doctors to serve on each of the evaluation panels that determine if a person is addicted and in need of treatment.

Bert Hoskin, chairman of the provincial Alcohol and Drug Commission, argues doctors and others working for the committee are absolved of liability by a clause in Bill 18.

But Dr Varnam said the protection is "legally iffy" and would probably be useless if the law were later declared unconstitutional.

That could happen if a court agrees Bill 18 is essentially criminal legislation, an exclusively federal responsibility under the British North America Act.

The Journal has learned Dr Varnam's committee has taken exactly that position, strengthening its earlier declaration that the act has "minimal health implications."

And the first challenge to the bill's validity was filed in October by the BC Civil Liberties Association.

A writ of summons asks the court to declare the law invalid:

• Because it infringes on a federal responsibility.

• Because it provides for "cruel and unusual punishment."

• Because it limits a traditional power of the court. Under the Act, the decision of an evaluation panel can be appealed to the Supreme Court of BC, but the court may only determine if the appellant is an addict in need of treatment; it may not determine the person's disposition.

The writ also asks for a declaration that the onus of proof that "a person is in need of treatment for narcotic dependency" rests upon the authorities.

It also seeks a declaration that the director seeking commital must demonstrate the treatment program is an effective cure for narcotic dependency.



Wayne Howell's column appears on page 12

Backgrounder

Drugs, bugs, and law

By John Shaughnessy

TORONTO — Canadian police investigating drug offences may "bug" a lawyer's home or office if the lawyer, a co-worker, or a close family member is believed to be involved personally in the offence.

Legally, priests and doctors are given no such protection. However, there is a "custom" against forcing disclosure of "confidential communications" made to these professionals. Although it's allowed, it's also unlikely a judge would allow police to "bug" a priest or doctor unless he was convinced that person was a party to the offence.

In Canada, the general rule is that it is illegal to intercept private communications by means of an electromagnetic, acoustic, mechanical, or other device. However, a judge of a superior court of criminal jurisdiction may authorize the interception of private communications connected with the investigation of serious offences where certain conditions are met by persons applying (to intercept) on behalf of a provincial Attorney General or of the federal Solicitor General.

Among the serious offences, Canada's Criminal Code lists trafficking, importing, or exporting contrary to the Narcotic Control Act; trafficking contrary to the Food and Drug Act; smuggling contrary to the Excise Act; and unlawful distillation and selling of spirits contrary to the Excise Act.

Before a judge gives any authorization to intercept private communications, he must be satisfied that, among other requirements, other investigative procedures have been tried and failed, or are unlikely to succeed, or that the urgency of the matter is such that it would be impractical to carry out the investigation of the offence using any other investigative procedures.

This, plus the "custom" against disclosure of confidential communications, suggests "bugging" of doctors and priests not believed to be involved in a drug offence, would be unusual.

The lawyer's protection is spelled out in the Code. It says a judge cannot authorize the interception of private communications at the office or residence of a solicitor or at any place normally used by a solicitor for the purpose of consultation with clients.

This prohibition does not apply if the judge is satisfied that there are reasonable grounds to believe "the solicitor, any solicitor practising with him, any person employed by him, or any other such solicitor or a member of the solicitor's household has been or is about to become a party to an offence."

In this situation, when an interception is authorized, the judge must impose conditions as he sees fit to protect privileged communications between solicitors and clients.

In any case, where a legally recognized "privileged communicaton" is intercepted, as when a lawyer on a legal matter telephones a client whose communications are being intercepted, the privileged communication is inadmissible as evidence in court without the consent of the person enjoying the privilege.

UK cannabis legalization 'a matter of urgency"

LONDON — The new campaign to legalize cannabis in the United Kingdom is gaining momentum as the British Home Office's (government department responsible for drug controls) advisory council on drugs prepares to issue a further study on the subject.

Latest throw in what some enthusiasts see as a crusade, is publication of a paperback* claiming British laws relating to the drug should be reformed "as a matter of urgency."

The book, published to mark the 50th year of cannabis prohibition here, claims present restrictions on use and possession of the drug are not justified by its potential for harm.

"It is true that people don't have to smoke cannabis, but the fact remains that very many choose to do so," it says. "Nevertheless many people in Britain, notably West Indians, choose cannabis as part of their culture, both for pleasure and as a herbal remedy. It is estimated that five million people in Britain have tried cannabis at one time or another.

"A survey carried out by the BBC in 1973 found that 39% of a sample of people aged between 17 and 34 had used it. The true figure will never be known mainly because the government had declined to support research in this area. One fact remains: in 1976 (the last year for which figures are available) 89% of convictions for cannabis offences were for simple possession (as opposed to drug trafficking) with convictions for cannabis totalling 78% of all drug convictions."

The book goes on to quote evidence from various United States sources which, it claims, shows moderate cannabis use is not harmful.

**The Cannabis Cover Up: Legalize Cannabis Campaign, 29, Old Bond St, London W.1. 65p*



Campaign to legalize cannabis in the United Kingdom is gaining momentum

Determined

(from page 1)

est was spelled out publicly earlier this year by Attorney-General Oscar Flores. "Mexican determination to continue combating crimes against public health will not falter."

Senor Flores is considered one of the most dynamic cabinet ministers in the government and one prepared to make hard decisions. As a state governor, he did not hesitate, despite the hardships he knew it would cause, to order half a million cattle destroyed to stop an outbreak of hoof and month disease.

Even if the Mexicans did agree not to spray marijuana crops but to spray only the poppy, it would be a useless venture. As one expert points out: "All the farmer would do then is plant one row of poppies next to a row of marijuana. What do you spray then?"

Sex offenders deny problem like alcoholics

By Betty Lou Lee

HALIFAX — Sex offenders not only have a high rate of alcohol abuse, but they use the same denial mechanisms as alcoholics in dealing with their problem.

If they are also alcoholics, they may continue to deny that problem after they have acknowledged their sexual problems.

Florence L. Nichols, psychiatrist at the Regional Psychiatric Centre (Pacific) Abbotsford, BC, told the annual meeting of the Canadian Psychiatric Association here that for more than 95% of the centre's sex offenders, alcohol and sometimes other drugs were associated with their offences.

'A social rape'

Most of the offenders committed rape or sexual assault with threats, but many deny their offences because of "shame, humiliation, and fear of disgrace or punishment," a situation analogous to alcoholism before it was more widely accepted as a disease, Dr Nichols said.

In the same way an alcoholic claims he's just a social drinker, or everyone drinks, or he drinks no more than anyone else, the sex offender claims he didn't do it, he was drinking: "She was asking for it" or, "it was what she really wanted."

"I'm half-expecting someday to hear somone say 'It was only a social rape.'

"When the plea of innocence fails, then may come the plea that alcohol made me do it. However, even suggesting that the man might be an alcoholie, or that alcohol played some part in his offence, was originally viewed with suspicion by patients and staff alike, and to a certain extent, still is.

"It was, and partly continues to be, perceived as blaming the alcohol and taking no responsibility for the forces within himself which led to the act," Dr Nichols said.

When the patient does accept the label of sex offender, "which is as loathsome to him as to many others, his self-esteem is very low and he cannot endure the possibility of yet another shameful, humilating label. Very often, after acknowledging that his sex offence sprang from his own troubled emotions, his denial of a sex offence changes to a denial of alcoholism and a disavowal that alcohol could have contributed anything to his crime.

"He now scorns and renounces 'the excuse of alcohol,' often in a very self-righteous, dogmatic way. Bad enough to be degraded with one label, two is too much. Perhaps, also, he fears giving up alcohol, his former coping mechanism to deal with life, his ever-present help in time of trouble."

Buried hostility

She described these men as coming from "ineredibly troubled and traumatic" backgrounds that left them with severely undermined self-confidence, deep feelings of inferiority and inadequacy, confusion, open or buried hostility, anxiety, and discontent.

"They all were left with troubling doubts about their ability to fulfil the social or sexual requirements of the masculine role.

"Most have discovered that alcohol and other drugs relieve these painful feelings by anesthetizing them from sombre reality, or producing exhilaration with deceptive feelings of self confidence or compensatory fantasies of gratification or revenge . . . .

"When alcohol or other mind-altering drugs are added to this already crippled personality, functioning with great strain and difficulty at best, with only marginal control, a further injury is added to the already damaged brakes of impulse control and the man is on a downhill collision course."

In getting them to accept both problems, Dr Nichols points out it is possible to have two disabilities at once, like cancer and venereal disease, or alcoholism and diabetes. She has also made attendance at Alcoholics Anonymous meetings an integral part of the sex offenders' program. "No one has to admit he is an alcoholic . . . he is encouraged just to come and listen."

Some of the offenders have suggested a program such as AA, a Sex Offenders Anonymous, and a "hot line" for those in the general population tempted to rape. Dr Nichols said there are few places an undetected offender can go for help without meeting ostracism or revenge, even though his acts shock and disgust him as much as others.

She said there are similarities in the roles fantasy plays for both alcoholics and sex offenders.

May lose control

"A non-alcoholic may have fantasies about his enjoyment of alcohol with friends and strangers, quite safely. However, if an alcoholic's thoughts wander wistfully to his past enjoyment of alcohol, without remembering the disastrous boomerang effect on him, he is in danger of losing his sobriety.

"In the same way, a non-sex offender may be able to entertain deviant sexual fantasies without acting them out, but it is very dangerous for a sex offender to encourage or allow his mind to dwell on deviant sexual fantasies.

"If the sex offender drinks or takes other mind-altering drugs, he may lose control not only of his thoughts and fantasies, but also his ability to control his behavior."

Quebec's Status of Women

Sexism causes illness

By Dorothy Trainor

MONTREAL — Quebec women are being made physically and mentally sick by their enforced passive role in society. And they are turning to drink and drugs as an escape route, a recent report by Quebec's Council on the Status of Women states.

They are dissatisfied with their role and alarming medical statistics mirror this dissatisfaction, according to the report. The report, which contains many recommendations, reveals that:

- Twice as many women as men went to hospital psychiatric wards with neurotic disorders in 1976 — a statistic which was determined by Quebec Health Insurance Board data.
- Twice as many women as men underwent psyehotherapy.
- Females take nearly twice as many prescription drugs as Quebec men and more of them use drugs that aet on the central nervous system.
- Alcoholism is rising sharply among Quebec women. The report estimates there are 100,000 female alcoholics and another 100,000 problem drinkers.
- The cause of so many women ending up in psychiatric wards could be they are unable to cope with an unrealistic role; this dependency being furthered by the medical community that does not recognize women as equal or independent.
- Women represent 52% of Quebec's population but only 72 of the province's 674 psychiatrists are women.

The Council recommends the Quebec government support research on women's use of drugs and alcohol. It also recommends the social affairs ministry help to sensitize health professionals in order to avoid sexist stereotyping.

It wants equal representation at decision-making levels, ie, government, unions, the courts, the church, and the health professions — all areas where women were excluded previously from decision making.

In brief, the Council seeks policy changes

All-women therapy a good approach

By Betty Lou Lee

HALIFAX — All-female therapy groups for women alcoholics were advocated at the annual meeting here of the Canadian Psychiatric Association by Barbara Unroe of Halifax, a nurse with Health and Welfare Canada.

She said they could be particularly helpful in dealing with problems and needs common to many alcoholic women: they learn they are not alone in those needs, they develop strong peer support groups, they develop new social outlets and ways of meeting social needs, and they can serve as rolc models for other women as they achieve sobriety.

"These group experiences help them deal with the sensitive areas in their lives without shame or guilt, allow them to deal with alcohol problems in the context of a woman's total experience in society and, most importantly, help women develop a positive identity as a whole person from which they can reach out with self-confidence to others."

Miss Unroe, who is with the promotion and prevention directorate, said such groups were working well in Halifax, where they have been established by the Provincial Commission on Drug Dependency, the Women's Centre, and a single-parent organization.

"Mixed therapy groups, be they professional-led or self-help, often act as inhibitors for women to explore openly and honestly sensitive areas in their lives, such as sexuality. There is a probable impact of labelling by her male peers if a woman discusses such things as extra-marital affairs, abortions, prostitution, or child abuse."

She said many women in treatment have reported the mental health system "is primarily engaged in adjusting women to the existing social reality, which all too often is to foster the stereotypical traditional female role of housewife, mother, or service worker, and not an opportunity to open-ended self-fulfillment with its many possibilities."

They are also often at a disadvantage in taking part in mixed-therapy groups, because they don't react as men do in group situations. Males have early experience in group processes and functioning as a unit through such avenues as sports.

"Men are encouraged to be assertive and vocal while women are taught to be passive and quiet. Therapists also expect women to bc passive and more dependent than men, even though they acknowledge these traits are not ideal for mental health.

"Thus, in mixed groups for treatment purposes, a woman may have to compete with men for attention. She may have to be aggressive or voeal or 'act-out' in order to get equal time, but behaving thus is going against the prescribed acceptable behavior for a woman and results in her being viewed negatively — unfeminine, aggressive, emotional, or sick."

Miss Unroe said any treatment modality offered to women alcoholics must remove "the practices of sex-role stereotyping, sex bias, and double standards if it is to provide effective and appropriate treatment and services to women."

The roles traditionally ascribed by culture and society to women are, in part, responsible for the differences in male and female alcoholics, shc suggested.

Her role as "carc-giver" is threatened by alcoholism, "and it is precisely beeause of its threatening nature to social order that women's alcoholism is left unreeognized until many of the social supports necessary for recovery are eroded.

"Women tend to feel guilty when drinking, whereas men tend to feel remorse." They feel guilty if they demand of others what others demand of them, and guilty when drinking because they can't fulfil their aseribed role of nurturing.

Men, however, are given caretaker roles that build confidence and competence. "It is a role which allows remorse to accompany the feeling of failure in an alcoholic man, rather than guilt."

In psychological tests, women have higher "turning against self" scores, while men have higher "turning against others" scores.

'Cold turkey' best way to quit

TORONTO — A California researcher says 90% of those who give up smoking suffer severe craving for cigarettes, irritation, and other withdrawal symptoms, and trying to cut down and taper off merely prolongs the agony.

"Cold turkey," is the best way, according to Saul Shiffman of University of California, Los Angeles. In a paper co-authored by Murray E. Jarvik, also of UCLA, Mr Shiffman told the American Psychological Association annual meeting here the first withdrawal week is the hardest. Studies show symptoms are less severe early in the morning and reach peak intensity in early evening.

The researchers based their conclusions on a smoking cessation clinic study in which 40 people participated. Some stopped smoking outright, while others cut down their smoking an average of 60%.

"The cold turkey subjects showed a greater reduction in withdrawal symptoms early in the abstinence period," he said.

Smokers who tried to banish the habit by cutting down found themselves plunged into a chronic state of withdrawal. Typically, this chronic withdrawal state will lead to relapse and return to the original rate of smoking, he suggested.

"It has become clear that the withdrawal symptoms are a major barrier to achieve and maintain abstinence.

"A major focus of research should be on developing effective treatments which specifically attack tobacco withdrawal symptoms and thereby discourage relapse. The health of millions depends on it."

Smokers cost dearly

GENEVA — Work absenteeism among smokers is 20% higher than for non smokers, says the chairman of a World Health Organization committee on smoking.

Sir George Godber says, in addition to work absenteeism, the financial toll taken by cigarettes includes the medical costs of smoking-related sicknesses, and providing benefits to families where the bread-winner has died of a smoking-related disease.

One result, he said, is that the cost to governments of smoking is greater than the revenue received in tobacco tax.



New Year's Resolution



In Appalachia, 'the belt buckle of the bible belt' . . .

Alcohol plan hits Moonshine, USA

By Harvey McConnell

SEATTLE — A service for alcoholics which is as spartan as the lives they lead, has been developed for residents of one of the most remote areas of the Appalachian Mountains.

Rod McMurray, of the New River Mental Health Center, Jefferson, North Carolina, said centuries of isolation and independence in Ash County, tucked in the mountains on the Virginia-Tennessee borders, coupled with fundamentalist religious roots, have dictated the service provided.

Ash County is one of only two counties in North Carolina where all alcohol is barred, including beer and wine. The 22,000 residents have an annual income of $4,400, and the majority live on isolated farms where they grow their own food and use wood for heating.

Mr McMurray told **The Journal**: "These people are very independent and self-sufficient. We still have folks here who dig herbs and bark trees for a living."

Although he is from "two counties down the hill" Mr McMurray found it took 18 months before he was accepted as a "good ole boy" and addressed by his first name.

The county may be dry but the people can still get "rid" — "store bought" — liquor easily. Cabbies stationed at two small stands in Jefferson, will take orders, go across the line into a wet county, buy liquor, and then deliver to the door. They expect to make a 100% profit.

Mr McMurray said "the police are trying to do something about it, but so far they have not had much luck. The cabs are really an illegal alcohol delivery system."

Mr McMurray said the area is "the belt buckle of the bible belt and most folks put a very heavy judgement on alcohol as being an evil thing. Thus, there is very little responsible drinking going on because people figure 10 drinks are just as bad as one, so they drink to get drunk."

Most of the drinking is confined to men, although Mr McMurray said they are now seeing some women with alcohol problems.

Large scale moonshining is out because of the price of ingredients, "although there are still farmers who keep a small still under the chicken house and make enough for themselves. A lot of them also make what they call 'beer' — a pretty awful tasting concoction which is about 15% alcohol," Mr McMurray added.

Instead of distilling corn liquor in the woods many of the farmers are now growing patches of marijuana. "Most of the folks growing it are the old moonshiners and they realize growing pot is a whole lot easier and a whole lot less expensive than making liquor." Mr McMurray said "they will not touch it with a 10-foot pole, and they don't make much money from it, as often a fast talking character will come through and buy it for about $100 a pound."

Mr McMurray said most of the alcoholics are referred to the program by a family member. To clinic staff, they'll say such things as "Fred is getting real crazy here lately."

Mr McMurray and his colleagues work with families. "The kind of therapy, if you want to call it that, that we do with the alcoholic population is very informal.

"I have to constantly remind myself not to use any jargon and talk in very simple terms. I will lose them, and they will distrust me when I say things they don't understand."

Mr McMurray and his colleagues insist the family attend three or four sessions at the beginning with the alcoholic. The family must provide transportation as well. Although the centre once had a transportation service, staff decided it was not efficient and it was discarded. Experiences dealing with mountain clients have led staff to run an extremely lean, budget-conscious service.

Mr McMurray said one recent experience was not exceptional. "I ran into a tobacco farmer who for 30 years drank a pint of liquor a day. His wife said she never saw him drunk.

"Well, it finally caught up with him and he had one of the roughest detoxes I've ever seen."



'folks put a heavy judgement on alcohol as evil'

New liquor advertising code: educators haven't repented

By Alan Massam

LONDON — The shock registered by the liquor trade here following the publication of a new code restricting drink ads on television has produced no sign of repentence from health educators.

In fact, during the launch of the Health Education Council's biggest "sensible drinking" campaign in the Northeast of England, HEC director Alastair Mackie took a hard swipe at drink advertising generally.

"The liquor trade's excuse — that their advertisements simply cause competition between brands without increasing consumption — is nonsense, as the enormous increases in the amount we drink and in such telling figures as teenage convictions for dunkenness show," he said.

Mr Mackie claimed the drinks trade exploited a gullible public by associating the product with other pleasurable things in life like holidays, sunshine, social aspirations and, above all, sex.

The new HEC campaign in the North-east is being coordinated by Peter Rorstad, director of the Northeast Council on Alcoholism.

He told **The Journal**: "There's an increase in the Northeast of alcohol-related problems among young girls. Nowadays, we have one female to two males seeking help for their drink dependency and this is higher than the national average.

"There is no doubt young people are making greater use of public houses for recreation and at an increasingly early age. Young men begin drinking as a demonstration of their manhood. Subsequently, they must continue to drink in order to maintain the respect of their peers and contact with them. So naturally, the girls go to public houses too where they will meet young men."

The campaign will also concentrate on drinking in the work place. One press advertisement shows an ambulance driving away from a factory, and warns about alcohol-related accidents with the heading: "After a couple of drinks at lunchtime, some people leave work a little earlier."

The ad also points out "drinking enough to make you slightly merry will also make you surprisingly dangerous."

IBA issues drink ad rules

LONDON — The powerful Independent Broadcasting Authority (IBA) has issued a new set of rules governing drinks ads on television which the brewers are said to be unhappy about to the point of gloom.

In future the ads will be expected to avoid the suggestion that drinks are bought in rounds; to avoid implying that refusing drink is a sign of weakness; to avoid depicting solitary drinking or 'sly grogging,' and to refrain from any suggestion the consumption of alcohol is associated with masculinity.

Furthermore, there must be no Rabelaisian scenes of wild alcoholic parties or drink ads associated with "dangerous machinery."

Additionally, the code insists drink should not be shown as having "therapeutic qualities" either as a stimulant, sedative, or tranquillizer, or as enhancing sexual or social performance.

And drink ads must not involve famous personalities with whom young people might identify themselves.

Regular students of British TV advertising are left wondering exactly how the advertising agencies will now be able to promote alcoholic drinks at all.

A very strict interpretation of the new code places very real doubts on some of the most persuasive drinks commercials — including one famous lager ad which claims the brand reaches parts other lagers cannot reach.

The Brewers Society is said to be seeking urgent talks with the IBA to have details of the code "clarificd."

Meanwhile, its comment to The Journal has been simply: "No comment."

Deaf communities hide alcoholism

SEATTLE — Deaf people who are also alcoholics are a minority within a minority and remain essentially untreated, according to Edith Watson, of the alcohol rehabilitation centre at Cleveland Metropolitan General Hospital.

One major reason they remain excluded is because of the protection the deaf community offers its own. The deaf mistrust the hearing world for a number of reasons, share a common identity, "and for self-protection they tend to deny the existence of alcoholism."

The deaf alcoholic is reluctant to admit to the problem and seek treatment, self-help programs for the deaf alcoholic are nonexistent in the deaf community, and "the outlook for the deaf is very bleak indeed," Ms Watson said.

Alcoholism agencies are designed for clients who can hear. Agencies for the deaf want nothing to do with alcoholics so each claims the deaf alcoholic is someone else's problem.

Ms Watson pointed out the deaf person often has a serious language problem and this results in many social and psychological problems.

One difficulty in dealing with deaf clients is that "certain abstract words are difficult to sign. In fact, it is probably impossible to communicate many words so that they are understood in the same way as hearing people understand and interpret the meaning.

"Counsellors must be alert for answers that indicate a question was only partially understood, or even completely misunderstood. There is a tendency among the deaf to say they understand when, in fact, they do not."

Ms Watson believes the most effective way to treat the deaf alcoholic is to intregate them with hearing clients as often as possible.

"The patient has probably spent most of his life isolated from the hearing world. He tends to think his problems are unique and . . . the result of his disability."

Pittsburgh research reveals alcoholics' reduced fertility

SAN FRANCISCO — Alcohol and its metabollte acetaldehyde have a direct toxic effect on the testes, according to a new study.

As a result of thls toxleity, chronic alcoholic men have a reduction in plasma testosterone, reduced fertility, atrophic testes, and inadequate secondary sex characteristics.

Until now, scientists assumed the reduced testosterone concentration in alcoholics was secondary to liver disease caused directly by alcohol.

The new study by workers in the departments of surgery and medicine of the University of Pittsburgh Hospital School of Medicine reveals alcohol and acetaldehyde are direct testicular toxins.

Frequently liver disease is minimal in chronic alcoholics, and is out of proportion to the reduction in plasma testosterone, they told the 6th Annual Clinical Congress of the American College of Surgeons here.

Investigators were Drs Charles F. Cobb, Michael F. Ennis, David H. Van Thiel, Roger Lester, and Judith S. Gavaler, BS. They found under stimulated conditions both ethanol and acetaldehyde reduced testosterone production in mice perfused with these solutions, which led them to believe the same occurs in humans.

McGill awards Marie-Victorin

MONTREAL — The 1978 Marie-Victorin prize for science has been awarded to Bernard Belleau of McGill University's department of chemistry. The award was made by Quebec's Minister of Cultural Affairs to Dr Belleau for the synthesizing of a pain killer that has the potential of replacing morphine.

The compound called butorphanol does not produce the side effects of morphine, but perhaps its most important attribute is that it is non-addictive.

Aluminum foil heroin cigarettes big with surfers



Surfers in Hawaii take to heroin 'cigarettes' in variation on GI practices during Vietnam War.

By Jean McCann

CHICAGO — The "surfing crowd" in Hawaii has taken up smoking aluminum foil "cigarettes" filled with heroin.

And because it's a needleless method of taking heroin, it poses a particular danger for youth who would never consider injecting themselves with a drug.

R. D. Hicks of the Drug Addictions Services of Hawaii and the University of Hawaii medical school, said here this form of heroin abuse is a variation of what occured during the Vietnam War. In Hawaii, heroin alone is being smoked, whereas in Vietnam it was commonly mixed with tobacco or marijuana.

Such abuse should be watched for, because it has the potential of spreading to the mainland of North America, if it hasn't already, and because this form of ingestion of the drug is as addicting as taking it intravenously.

In fact, he said, there is evidence that many of the smokers are not native Hawaiians, but Caucasian immigrants from the United States West coast.

Dr Hicks said this was documented in a study of heroin smokers, who were compared with intravenous (IV) users in terms of sociological and medical information.

"In approximately 1971, a new form of heroin use became popular in Hawaii, and has thus resulted in a unique sub-subculture". At that time, he said, a study was undertaken "to document the fact that smoking of heroin can result in addiction, and to compare smokers and intravenous users of heroin."

Most of the 15 men and five women heroin smokers gleaned from the Drug Addiction Services population, which provides counselling and methadone detoxification, were Caucasians, although this isn't the predominant racial category in Hawaii.

"The social data are also significant, in that approximately 50% of smokers were employed full-time, whereas 55% of IV users were chronically unemployed." There were also far fewer criminal records in the heroin smokers than in the IV users.

Most users were concentrated in the North Shore of Oahu Island, the area where "the surfing crowd was introduced to 'opium rocks' which they were informed they could smoke with no risk of addiction. These opium rocks were actually heroin, and even though users now realize tolerance and addiction occurs, the heroin continues to be smoked, and initiates are added daily. The smoking also continues to be restricted primarily to the same geographic area."

Dr Hicks said there is no documentation of the supply source.

Hawaiian culture crisis and PCP

CHICAGO — Young Hawaiians are abusing phencyclidine because they have difficulty adapting to the technical society which now abounds in their formerly more leisurely land.

R. D. Hicks, of the Drug Addictions Services of Hawaii, and the University of Hawaii medical school, said here: "The interest in PCP seems to stem from the fact the locals have incorporated drugs more into their lifestyle, and thus are more inclined to become involved with a new drug like PCP. Further, these youth have very little money, and the relatively low cost of PCP makes it even more attractive.

"In addition, it must be noted that the locals seem to have the greatest ethocultural identity problems. The other Pacific Islands still use their own native language and follow many of their traditional customs. This is not true of the locals, who are English-speaking, and who are unsure of their allegiance to Hawaiian culture, although they describe themselves as Hawaiians."

Dr Hicks said his study showed also that even though the PCP users were aware of the bad side effects, and the drug's "mean" reputation, they continued to use it.

"It was clear the fragile or vulnerable self-concepts and needs for risk-taking, coupled with the pressure for acceptance, outweigh the pressures of rational judgment regarding the potentially harmful sequelae. PCP was used socially at all times, and was combined with listening to music, or relaxing at the beach.

"Perhaps because of the amnesia induced by the drug, a common finding is the inability of the user to articulate a description of the effect, except for 'wowie,' 'cloud nine,' 'far-out,' or 'zap.' These phrases are often accompanied by a throwing back of the head, a rolling of the eyes, and an opening of the mouth in an almost reflexive manner."

Study explores mood disorder in Irish alcoholics

HALIFAX — A study of Irish male alcoholics admitted to hospital indicates 20% of them had a co-existing affective disorder. This is one of the highest rates in the literature.

Of 106 such patients, 82 had unipolar illness (66 depression and 16 elation) and 24 had both the depressive and manic mood swings of bipolar illness.

When compared to a group with primary alcoholism, and no psychiatric disorder, there was no difference in their drinking histories and little difference in demographic items or social and family history. The affectives had significantly more depression among siblings and the extended family members.

The affectives were slightly older (45.3 years compared to 42.8). They had an average of 4.47 months of unemployment over the past 10 years, compared to 2.65 for the primary group.

Results of the study were reported to the annual meeting of the Canadian Psychiatric Association here by Karla B. O'Sullivan, now of Regina, who was consultant psychiatrist at St. Patrick's Hospital, Dublin, when the study was begun in 1974. It is sponsored by the Irish National Council on Alcoholism, and funded by Irish Distillers Ltd. A follow-up study of the 194 primaries and 106 affectives two years after discharge is still underway.

Dr O'Sullivan said the affectives had a shorter drinking episode prior to admission (27 weeks compared to 39), and had been admitted to hospital more often (3.9 times compared to 2.4).

They were more likely to receive anti-depressants and electro-convulsive therapy, and to stay longer in hospital (44 days compared to 34).

Dr O'Sullivan said the study was to explore the relationship between alcoholism and affective disorder in the Irish because their first admission rate for alcoholism is 24.5 per 100,000 population, second only to France's 28.3, and first admission rates for psychiatric disorders is also one of the highest in the world at 229.5 per 100,000.

The hypotheses were that a significant portion of hospitalized alcoholics would show clear-cut affective disorder, and that they could be distinguished by family history, drinking patterns, and treatment outcome. The latter factor awaits results of the follow-up study.

To get 300 for the study, 508 consecutive male admissions were assessed. Nine per cent were excluded because of serious physical ill health and 11% because of psychiatric ill health other than affective disorders. Others didn't meet the age (18 to 65) or Irish residence criteria. Internationally accepted criteria for alcoholism and affective disorder were used by the research team, which was not involved in clinical management.

Dr O'Sullivan said 9% of the affective group reported affective illness before the onset of alcoholism.

He said the longer and more frequent periods in hospital may be because the patient seeks treatment for the distress of his co-existing mood disorder. But doctors also may be motivated to get more actively involved in management because of the potentially treatable psychiatric condition.

Psychotherapy costs OHIP 3% of total

LONDON, ONT — Psychotherapy by psychiatrists accounted for 3% of the total payouts of the Ontario Health Insurance Plan (OHIP), or $2.50 per capita in 1976.

The figures were presented to the fall meeting of the Ontario Psychiatric Association by A. L. Lesser of Hamilton, past chairman of the Ontario Medical Association. It is believed to be the first study to give a breakdown on psychotherapy costs, and was made as a result of indications in the past few years that OHIP benefits for psychotherapy might be curtailed as a way of cutting medical costs.

Dr Lesser said although the 716 psychiatrists in Ontario in 1976 were 12% of all specialists, they accounted for 7.8% of OHIP payments to specialists. They were 5.7% of all doctors, and got 4.4% of money paid to all doctors.

They were paid a total of $29,486,000 of which $20,787 was for psychotherapy, and another $13,500,000 was paid to about 12,000 others for psychotherapy, mainly family doctors. (Only doctors can bill OHIP).

The figures do not suggest over-utilization by the consumer or widespread abuse by doctors, Dr Lesser said. Since psychotherapy is time-related, this mitigates against abuse.

He urged that cost-benefit studies be done in Ontario. In other countries they have shown that at least psychotherapy under six months is cost-effective: it results in less hospitalization and use of other medical services.

He also suggested peer review procedures for long term psychotherapy "in cases involving interminable or life-long therapy, or where there is a question of a psychotherapeutic modality being used without the prerequisite training from a recognized teaching centre."

Switzerland's warning

BERNE, Switzerland — All packages of cigarettes and tobacco sold in Switzerland must now carry warnings that smoking can be harmful to health, and list figures of tar and nicotine levels, the government has decided.

The ruling took effect November 15.

The government also banned advertising aimed specifically at encouraging young people to smoke, and it forbade manufacturers to give youths free cigarettes.

Vancouver's skid row opens Minister's eyes

VANCOUVER — The man in charge of the British Columbia Liquor Administration Board, Consumer Affairs Minister Rafe Mair, had an eye-opener when he was beset by drunks in Vancouver's skid road area during a tour at the end of Alcohol Awareness Week (The **Journal**, Nov).

Some clung to his sleeve, others reeled out of local liquor stores having been served while obviously intoxicated, and others lurched around beer parlors despite the law that forbids providing intoxicating beverages to people already drunk.

The tour was arranged by Bruce Eriksen, president of the Downtown Eastside Residents' Association, who for a number of years has crusaded against municipal and provincial governments, and attacked slum landlords, in sometimes desperate efforts to improve the lot of "down and outs".

Mr Eriksen has persistently waged war on hoteliers who fatten their pocket books by selling liquor to men who obviously have had more than they can reasonably take.

Said Mr Mair: "There's no doubt about it, it's a hell of a problem . . . but I do not intend to let the matter sit."

He said it would be impossible for him to come up with an instant answer . . . "It's not that simple . . . Maybe I'm not living up to my responsibilities."

He said the liquor store clerks may be selling liquor to drunks in order to avoid a physical struggle. "If that's the case they are in a very difficult situation and they are going to get help."

One possibility he raised was stationing special police to prevent customers causing trouble.

Mr Mair said he half-expected to find a staging of events for his tour. However, the idea was quickly dispelled. "If this wasn't spontaneous, it was the greatest piece of acting since the Globe Theatre in Shakespeare's time."

And Mr Mair acknowledged that alcohol sale is just one aspect of inter-related social problems.

What he saw in the East Hastings Street area was a microcosm of the political jigsaw he finds himself in as both advocate and controller of liquor in the province.

On the one hand, the provincial government is launching a $2-million educational program to warn about the effects of alcohol. On the other, the same government is raking in $180 million a year in liquor sales profits.

EDITOR
Anne MacLennan

STAFF WRITER/PRODUCTION EDITOR
Karin Pargas

CONTRIBUTING EDITORS
Jeff Carruthers (Ottawa)
Harvey McConnell (Washington)
John Shaughnessy (Toronto)

SCIENCE EDITOR
Dr Ruth Segal

The Journal

Published by Addiction Research Foundation of Ontario
33 Russell St, Toronto, (416) 595-6053

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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Comment

BC heroin plan: 'Worst is to come'

Like a stagecoach fleeing attacking Indians across a rocky plain, British Columbia's compulsory heroin treatment plan finds itself speeding toward its goal but with no guarantee of arriving in one piece.

A legal challenge, a doctors' revolt, and administrative delays are besetting it on the eve of implementation (See Problems p 1). And the worst is likely yet to come.

For one thing, the legal challenges are likely to multiply when the first unwilling bodies are brought into the plan starting Jan 1 (or maybe Feb 1, depending on slippage).

"Everyone will wait to see how the first few test cases go," says Bert Hoskin, chairman of the BC Alcohol and Drug Commission and father of the scheme, when he was asked if the commission expects a flood of addicts.

Certainly, early experience is not encouraging.

Nearly halfway through a three-month grace period, only 12 addicts had turned themselves in, in response to advertisements offering withdrawal with no record kept of the treatment.

That's definitely a trickle compared to the $16 million a year plan's ambitions.

"We've planned a machine — that's the wrong word — a facility that will cater to 2,500 in treatment at peak and 5,000 in aftercare," Mr Hoskin said, "and don't use the word 'machine' or that's your last interview with the commission."

There will be five area coordinating centres responsible for "security and community supervision," 11 treatment clinics, five community support units, and, in about six months, one therapeutic community. The commission is hiring 252 full time staff and 111 auxiliaries to run the program.

When a suspected addict arrives at a centre he will be examined and assessed within 72 hours. Although the law provides for detention during this time, Mr Hoskin said the addict will ordinarily be turned loose except when required for examinations or interviews.

At the end of the assessment, he is told if he is "an addict in need of treatment" and given a copy of the report of an evaluation panel.

He is asked to decide, on the spot, whether he will sign a committal order or appeal the evaluation to the Supreme Court.

The first court challenge touches this procedure at several points.

Can a self-committal be withdrawn? Can a detained person get access to legal counsel? There are many questions to be settled.

And, of course, the law may be declared entirely unconstitutional. The biggest danger is if doctors as a body declare it is not health legislation but criminal legislation. That official opinion would be a powerful force in a court considering whether the law is outside provincial jurisdiction.

The first challenges are unlikely to get into court before spring, and the proceedings will be lengthy, says Jim Dybikowski, president of the BC Civil Liberties Association.

It's a long way to Dodge City.



'But dammit! Like they didn't even mention smoking pot!'

Letters to the Editor

The pizazz of Szasz

Regarding Interview with Szasz (The Journal, Oct), Dr Szasz seems to be echoing what increasing numbers of us in the field have been voicing without, of course, the crisp candor which has become the controversial hallmark of the good Professor.

By this time, most of us should be aware of a growing trend which is moving us further away from the conventional disease models of addiction, especially in the light of our varying experiences with so many attempts at treatment based on such models — such as the addiction displacement models, many of which have been beset by failure from their very start.

Here again, there continues to be much disagreement as to what should properly constitute a "success," since we have so many divergent philosophies about what sort of creatures people are supposed to be.

The direction we seem to be taking is toward a more integrated, holistic model: a view which sees the "addicted" individual as a person who is pathetically trying to fabricate a crude mechanism to supplant his self-conceived existential deficits through a synthesis of, and bondage to, those exogenous materials which are capable of producing some sense of well-being, feelings of "wholeness," and, hopefully, create for himself a condition of transient equilibration.

To label those who lack understanding of their own inner space as "diseased," makes about as much sense as similarly labelling those of us who lack comprehension of quantum mechanics, although a physicist might think differently.

Sterling W. Holman, PhD,
Director,
Crisis Intervention Programs
Fort Hall, Idaho

'Forerunner'

As a subscriber to The Journal, I have found practically every issue quite interesting and realistically pertinent to the field of addiction rehabilitation. I would have to believe that your monthly paper is definitely the forerunner compared to the many publications of this nature I have read.
Paul Mackler
Substance Abuse Council of Hillsdale County
Hillsdale, Michigan

More science

I would like more scientific articles, eg Harold Kalant in court, (The Journal, Oct, Nov) where one has scientific proof of harmful effects of drugs and alcohol. I find these articles help a great deal in motivating youngsters who feel their drugging is not doing them any harm.

It would also be nice if there were articles about new treatment programs and therapeutic communities.

Many thanks for The Journal.

Miss J. Frost
Auckland Park
South Africa

'Informative'

The Journal is informative and interesting — a good combination. I wish it had a wider international coverage.

Prof R. Mechoulam
Hebrew University
Jerusalem, Israel

The Journal welcomes Letters to the Editor. Letters bearing the full name and address of sender may be sent to: The Journal, 33 Russell Street, Toronto, Ontario, M5S 2S1.

Special supplement to

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

The Year in Review



Headlines and Headliners

January

- Cocaine brain damage being seen in Bolivia
- Chinese heroin supply is on increase in UK

February

- Francoise Berthiaume, executive director, quits the Canadian Addictions Foundation
- Butyl nitrite phenomenon identified

March

- Mexican poppies are top US target
- Number of Canadian who kick cigarettes increasing
- Vigorous anti-smoking drives proposed for US
- Alcohol/sedative mix could damage kidneys
- New Zealand moves to seal off drug traffickers
- French marijuana laws under attack

April

- Quebec adds 8,000 new wine outlets
- US announces new cocaine strategy
- British Columbia announces plans for compulsory treatment of heroin addicts
- Paraquat found on cannabis in San Francisco
- Canada's Donald Smith named to head international drug strategy study
- Cocaine moving into Europe
- Illicit psychotropics world danger

May

- Equal Rights Amendment shakes up National Drug Abuse Conference in US — minorities threaten boycott
- Paraquat risks simply unknown, says US National Institute on Drug Abuse director
- Alcohol and marijuana use an increasing problem for Canada's military
- US Food and Drug Administration gains more power in President Jimmy Carter's drug law overhaul
- US high schoolers favor 1) tobacco 2) pot 3) alcohol
- Operation Julie in UK smashes world LSD supply
- Nicotine zap from aerosol may replace smoking

June

- US servicemen abusing drugs at alarming rate
- Canadian Justice Minister Ron Basford proposes diverting drug addicts to medical treatment before conviction of crime
- Loran Archer becomes acting director of the US National Institute on Alcohol Abuse and Alcoholism, replacing Ernest Noble
- Paraquat scare sparks new push to legalize home grown marijuana

July

- British Columbia plan for compulsory treatment of heroin addicts set to start in January, 1979
- Jan DuPlain resigns as executive director of the office on women of the US National Council on Alcoholism
- Cocaine infiltrating Europe via more new border points.
- Hong Kong dismayed at seriousness of its alcohol problem
- Grim tales about PCP may prompt stricter legislation
- Pot legalization campaign heats up again in UK
- Paraquat spray is Mexico's concern, says United States federal judge

August

- Peter Bourne resigns as special adviser on health issues to US President Jimmy Carter
- The 1979 US National Drug Abuse Conference in jeopardy
- Karst Besterman appointed acting director of the US National Institute on Drug Abuse, replacing Robert DuPont

September

- Singer Gordon Lightfoot is acquitted of drinking and driving charge and sparks debate on validity of breath sample evidence in Canadian courtrooms
- Canada's Non-Medical Use of Drugs Directorate shifted to Health Services and Promotion branch of the department of national health and welfare. Ron Draper, Non-MUDD's director general, named director general of new Promotion and Prevention Directorate
- Legal file closed on Peter Bourne
- Australia introduces life imprisonment as maximum penalty for importing large quantities of illicit drugs
- ARF launches School for Addiction Studies

October

- Canada's drug budget slashed
- Alcohol and Drug Problems Association of America joins exit from joint meet with NDAC in New Orleans

November

- Canadians are more liberal in their attitudes to marijuana than has ever been suspected
- Montreal's heroin addict population is rising
- Afghanistan's new leaders are committed to help stem Middle East heroin flood.
- A ban on cigarette advertising is urged for European Economic Commission countries



Canada: Political Report

By Jeff Carruthers

First of all, they said it had to be done. Then they said it couldn't be done. Now, with any luck, thousands of Canadians will be able to find out just exactly what "they" have been doing.

"They" are the federal bureau of dangerous drugs in the department of national health and welfare, headed by Reid McKim.

What they said had to be done was to collect, collate, and eventually computerize information on hundreds of thousands of Canadians who were known or suspected of using or distributing illicit drugs, including the opiates, hallucinogens, and, most often, cannabis.

During 1978, **The Journal** sought to answer some standard questions of journalism: who, what, where, why, and how.

Who was affected by the files? What kind of information was contained in them? Where did the information come from and go? Why was it needed and, especially, why was it so secret that not even a named individual could find out what the government had on him or her (to check its accuracy, for example)? And how could something be done to change the situation?

The rationale offered **The Journal**, when routine inquiries were first made, was that the information was needed to establish drug use trends in Canada, for domestic and international needs. It was part of the department's mandate and Canada's contribution to international drug control efforts under the United Nations.

Following a number of articles questioning the accuracy of some of the information, and the need for it in such personalized form, the bureau added a new rationale: the information was needed for the Health Minister to decide how to dispose of drugs and other items found or seized in connection with drug crimes.

Soon after, with the introduction of new Human Rights Legislation allowing Canadians the right to see information on themselves in government files, it seemed for a brief period people would be able to learn what was so secret in the files.

However, the bureau, in conjunction with the justice department and the RCMP, convinced the federal cabinet that information in the drug files was so sensitive it should be kept totally secret, under special provisions of the Human Rights Act normally reserved for intelligence files containing information on national security or on ongoing criminal investigations.

As later became evident, the cabinet and, in particular, the Health Minister, were conned.

For their troubles, the bureau officials who managed to obtain the special cabinet secrecy order without too many questions asked, found themselves highly embarrassed when much of the same, supposedly highly-sensitive information contained in RCMP files, was found to be open to the public.

Until this moment, in the early summer, the bureau officials had argued vehemently that there was no way any sensitive information could either be screened or segregated, so that at least information derived from the public record — information on known drug convictions, for example, which makes up the bulk of the information — could be opened for affected individuals.

Evidence emerged that senior departmental officials had also been misled to believe the department had no choice but to make the files totally secret, and that other federal agencies were blocking keeping the files at least partly open.

The Human Rights Act requires that active steps be taken by cabinet and government only to keep a data bank totally secret; otherwise, sensitive information can always be censored out by the government, if necessary.

However, by keeping the file totally secret, some government officials realized the public wouldn't be able to find out anything, including whether a file existed on them.

When the matter was finally brought to the attention of Health Minister Monique Begin, she launched an immediate investigation into the why's and wherefore's. Within a month, she promised to open the files to public scrutiny by people named in the files. Five months later, after some foot-dragging, the secrecy was lifted — the only case to date in which such a secrecy order has been revoked.

United States: Political Report

By Harvey McConnell

It's one of the most severe blows the drug and alcohol field has suffered. That was one of the epitaphs for Peter Bourne, following his departure in July from the White House staff.

"Severe blow" applies to many events in 1978 in the substance abuse field.

In the space of a few months, out went Dr Bourne as President Jimmy Carter's advisor on health issues; Robert DuPont as director of the National Institute on Drug Abuse (NIDA); and Ernest Noble as director of the National Institute on Alcohol Abuse and Alcoholism (NIAAA).

The year also saw other major disruptions. Ardent equal rights supporters threw the National Drug Abuse Conference into chaos, with the net result a hiving off of many minority groups from the scheduled August 1979 meeting in New Orleans.

At the same time, the Alcohol and Drug Problems Association (ADPA) withdrew from a co-located meeting with NDAC and will now hold its annual conference in Washington in the same week as the NDAC. Dissidents from the NDAC hope to hold a national drug conference in conjunction with the ADPA.

The resignation of Dr Bourne was the single most important event. Augustus Hewlett, executive director of ADPA, summed it up: "I don't think many in the field itself understood what an advantage we had with someone of Peter's calibre having the President's ear."

Dr Bourne now spends his time lecturing and writing.

Dr Bourne, in his 18 months, pushed for research to see if heroin and marijuana might have legitimate clinical value and tried to persuade doctors to cut down on prescribing barbiturates. On the policy level, he had begun stressing the reality that eventually all substance abuse — ranging through heroin, alcohol, and tobacco to tranquillizers — will have to come together under the same umbrella.

On the international level, he argued persuasively for a global fight against drug abuse and trafficking, and convinced many Americans that the problems at home are not unique.

NIDA's Dr DuPont, respected and admired by workers in the field as well as by leaders, was almost alone among high level career bureaucrats in Washington in having consumate political skills and knowing how to use them. Dr DuPont is now advisor on health matters to the American Broadcasting Company program "Good Morning America."

Lack of political skills caused Dr Noble a rough ride when he took over as head of NIAAA although in his two years in office he won the confidence of many in the field. Dr Noble now works on programs for the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) and will return eventually to the University of California at Irvine.

The most important individual now is Gerald Klerman, director of ADAMHA, and the man who forced out Drs. DuPont and Noble. Dr Klerman left Harvard on a leave of absence a year ago to take the ADAMHA job, offered by Joseph Califano, secretary of health, education, and welfare.

Dr Klerman himself will probably have a new boss in January. It is rumored that, in a cabinet reshuffle, Mr Califano will become attorney-general when Griffen Bell returns to Georgia.

Right now, Dr Klerman is studying a short list of candidates for both the NIDA and NIAAA director's jobs. Dr Klerman, in turn, will have to decide by the end of 1979 whether he will remain at ADAMHA or return to Harvard.

Whomever is chosen to head the institutions, it is certain they will have to deal with a dwindling money supply and prevention, treatment and research financed from Washington are going to suffer financially.

Despite this bleak year-end picture, however, many experts see as one positive feature the move to push substance abuse into the mainstream through such programs as occupational assistance and the private health insurance plans.

BC's Heroin Plan

By John Shaughnessy

Last July, British Columbia launched the most dramatic and controversial attack on heroin addiction in Canadian history.

The Heroin Treatment Act, passed by a vote of 29 to 16, for the first time in Canada allowed the government to direct people "found dependent on a narcotic" into a compulsory three-year treatment program. It also allowed detaining such people for six-month periods in special cases.

Prior to passage of the Heroin Treatment Act, no one committed an offence by, or could be directed into treatment for, *being* an addict. Criminal drug offences, under the jurisdiction of the federal government, were restricted to possession, trafficking, importing, and exporting of drugs.

The Heroin Treatment Act, framed as health legislation and thus within the jurisdiction of the provincial government, does not label anyone an "offender": it does permit government officials to direct those found dependent on a narcotic into a compulsory treatment program.

Criticism of the BC legislation has come from several fronts. Lawyers in the BC Bar Association have objected because it seriously deprives a citizen of his or her civil liberties. They argue that the "minimums" in the legislation do not allow for individual responses to treatment and reflect more of a penal philosophy than a treatment approach. In addition, they criticize the program because it allows potential confinement of a citizen without an offence having been committed.

Addiction specialists say the success rates of existing therapies are not high enough to justify forced treatment for anyone. Civil liberties groups such as BC's Ad Hoc Committee on the Compulsory Addiction Treatment Program claim the legislation offers no realistic treatment prospects.

British Columbia's doctors also opposed the legislation. They felt the new law put doctors in the position of judges — determining whether a person was "in need of treatment" — and was antithetical to the doctor-patient relationship.

Provinces adjoining British Columbia expressed dismay at the radical step taken by the west coast province. Addicts in BC, fearing compulsory treatment, would simply move out to more tolerant jurisdictions, they said.

Despite the criticisms, the BC government and the provincial Alcohol and Drug Commission, which will administer the program, are confident the new law will work. They see the Act as the legislative framework for an effective program for treating and rehabilitating the province's estimated 7,000 to 10,000 addicts.

Program plans call for the setting up of one residential treatment centre for 150 patients, two therapeutic communities, at least five regional clinics, and a number of community clinics. The program is geared to handle 2,500 addicts.

BC Health Minister Robert McClelland, said last June the government decided to institute the program because of "public demands to take some type of positive action to combat the growing problem of heroin addiction, and because voluntary treatment programs had had little successs in attracting patients." He said the program is a five-year demonstration project, "and if it isn't working at the end of that time we'll scrap it and try something different."

At year's end, initial program plans had been modified. The program was originally scheduled to start January 1, 1979, but its complete implementation had been delayed. Police will not begin issuing notices to "potential addicts" to appear for evaluation until April 1. From January until April only voluntary patients and those referred by the courts will be accepted into the program.

The Clinics

By John Shaughnessy

For smokers, particularly women, 1978 was bad news.

In March, we reported an American study indicating women who smoke and use the Pill have a three times greater chance of dying from a heart attack or other circulatory diseases than women who take the Pill but do not smoke. The study convinced the United States Food and Drug Administration that pharmacists should issue a warning leaflet about the dangers with every prescription filled for the Pill.

Later in the year (June), cigarette smoking was associated with cervical cancer. A Swedish study indicated a rate of cervical cancer of 20.2 per thousand in women who smoked compared to 4.0 per thousand in women who had never taken up the habit.

A report from Paris announced the ominous news that smoking is the highest risk factor in the development of chronic bronchitis among women (Aug). Male smokers have a risk 1.6 times that of non-smoking men, but women smokers' risk is 3.3 times that of their non-smoking sisters.

Non-smoking cardiac sufferers had their complacency shattered by a California study suggesting angina can be induced if they sit in a room near someone who is smoking a cigarette. Ten men were tested. After they sat near a smoker they could not exercise for as long as usual. Some developed premature ventricular (irregular) heart beat.

California doctors reported significant lung damage among men who smoked an average of five marijuana cigarettes a week for at least two years. The damage was greater than that seen in a control group who did not use marijuana but smoked an average of 16 or more cigarettes a day (June).

Bad news greeted those who favor alcohol. Some beers in Europe and the United States were found to contain small traces of nitrosamines, a carcinogenic agent.

An Ontario doctor warned that combining alcohol with sedatives or tranquillizers can cause acute kidney failure. A type of kidney shutdown usually associated with crush injuries can occur as a result of one binge if sedatives or tranquillizers are added to the alcohol.

Alcohol and sedatives sound dangerous. But a gin and sandwich? British researchers reported (May) that hypoglycemia can result from consumption of a sub-inebriating dose of alcohol plus carbohydrate-yielding food. The symptoms appear several hours after lunch — undue fatigue, lack of concentration, and an increasing tendency to commit errors of judgement.

There *was* some good news in 1978.

A centre in the west of England claimed a 78% success rate in treating and rehabilitating alcoholic patients in a trial which lasted 2½ years (June).

A Toronto physician outlined the importance and benefits of sex therapy for the recovering alcoholic (June). Janet Dowsling said therapy should not begin until about three months after initial treatment for the alcoholism, and should not be given unless the recovering alcoholic requests it, but that failure to solve sexual problems will inhibit recovery as a whole.

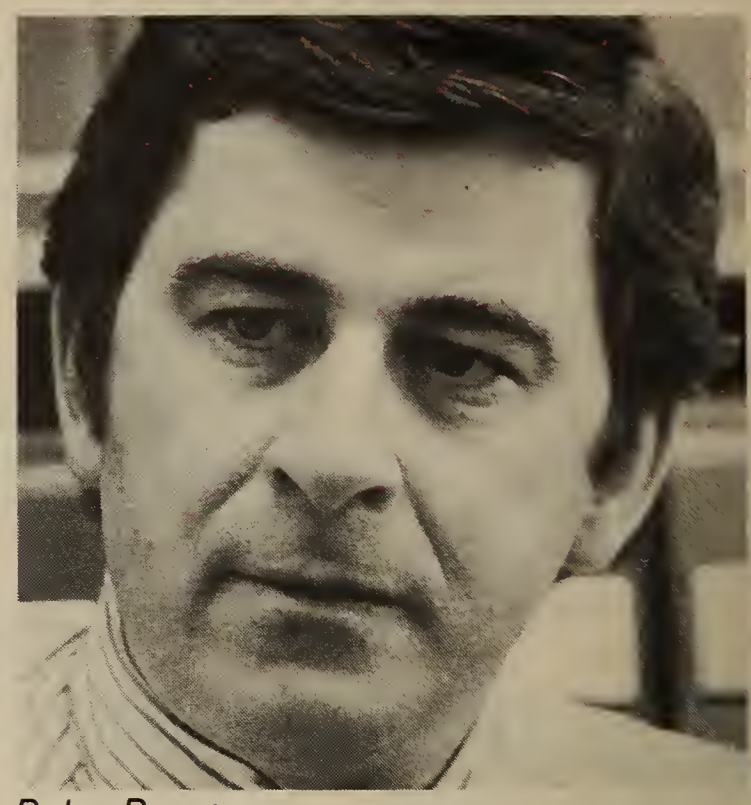
Neuro-electric therapy for drug addicts is under investigation (May) in Britain. The treatment, based on traditional Chinese acupuncture, is said to eliminate withdrawal symptoms and to remove craving for drugs and alcohol.

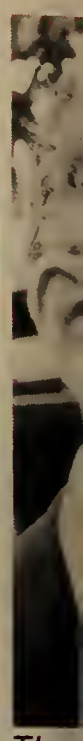
Acupuncture and electro-stimulation achieved "significant results" in treating dependence on heroin and opium in a Hong Kong study (Sept).

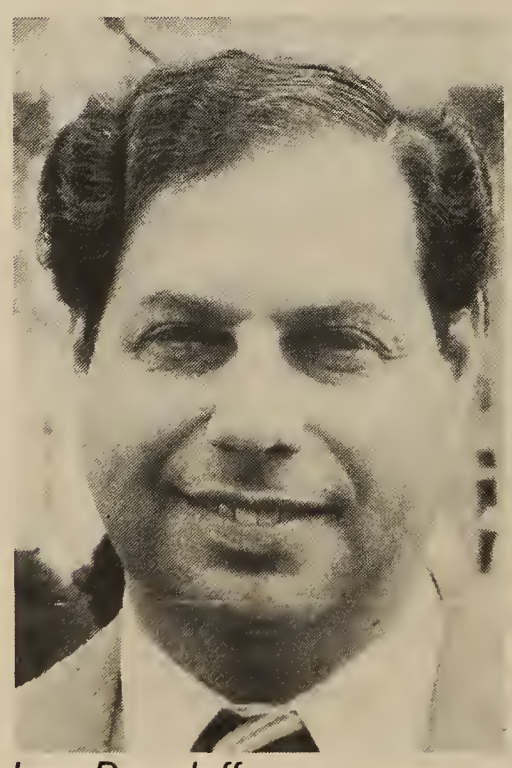
In a Manitoba trial, long acting disulfiram implantation in 600 alcoholics caused 85% of them to give up drinking and the majority later to join rehabilitation programs (Sept).

They sai


Thomas Bryant


Peter Bourne


Thor


Lee Dogoloff


Maria Bostos


Margo St James

January

'. . . If we don't decriminalize drugs and prostitution at the same time, the streetwalker will still be out there, trying to get to the customer in the fastest way possible. She wants to avoid the waiting that a 'call girl' or 'parlor worker' has to do . . .' Margo St James, founder COYOTE (Call Off Your Old Tired Ethics).

'. . . Most of the money for drugs coming into Colombia is without doubt provided by criminals in North America. But the business here is controlled completely by Colombian criminals . . .' an anonymous observer of the Colombia cocaine scene.

'. . . I will never forget where I came from — the jungle of the streets — and it is important, when treating Chicanos, not to take away the survival skills they have learned in their barrios . . .' Ramon Adame, president, Chicano Alliance of Drug Abuse Programs, United States.

'. . . Women feel as second-class citizens. They have been seen as the help-mate of the male, a paragon of purity, the mother of the race, and the one who can do no ill. Consequently, when society sees a woman as alcoholic, she is cast into the role of a fallen woman — one who is to be disgraced, neglected and negated . . .' Dr Jean Kirkpatrick, founder, Women for Sobriety Inc.

'. . . It seems to me that the smart people and the powerful people in the world are literally turning the other direction and saying nothing . . . about what the policy implications should be or anything else. It's as if we've all joined a conspiracy of silence on the subject (of cannabis) . . .' Dr Robert DuPont, director of the United States National Institute on Drug Abuse.

'. . . In general . . . there have not been many international studies concerned with alcohol and drug use. In fact, we're in the position of having to judge a beauty contest where there are not enough contestants . . .' Dr Reginald Smart, associate research director, evaluation studies, Addiction Research Foundation of Ontario.

'. . . If, in India, for example, we accept western dress, jeans, Coca-Cola, music, stereos, and tape recorders, and all that, unless there is a rejection of the value system, it would be very difficult to keep out only alcohol and accept the rest of the social things . . .' Dr Narendra Wig, Post Graduate Institute of Medical Education Research, Chandigarh, India.

February

'. . . If the man, whether he is married or single, does not go out to drink on Friday night, he is considered a homosexuat. And if a woman goes out on Friday night, it is certainly not to drink, or she is looked upon as easy . . .' Maria Bostos, clinical psychiatrist, National Institute of Drug Dependence, Bolivia.

March

'. . . Smoking is a form of slow-motion suicide and Public Health Enemy Number One in the United States . . .' Joseph Califano, secretary, United States department of health, education, and welfare.

'. . . The efforts taken in Mexico to destroy narcotic raw materials, such as the opium poppy, before they enter illicit channels, are the most effective and most cost efficient means of decreasing the flow of drugs such as heroin into the United States . . .' Dr Peter Bourne, director of the United States Office of Drug Abuse Prevention.

'. . . We find that there are treatment agencies for the rich, and treatment agencies for the poor, and that the agencies for the rich have far larger publicly financed budgets than those for the poor. These are expensive agencies, which go into short term residential type of care, and have a clientele of higher educational and income background than the other agencies . . .' Dr Angus Reid, assistant professor, department of social and preventive medicine, University of Manitoba Medical School.

April

'. . . Alcohol here plays the role of psychiatry in the West — I think (Japan) would explode without it . . .' a foreign diplomat stationed in Japan.

May

'. . . The continuation of racism and sexism directly affects the quality of treatment and the ability of drug workers to successfully deliver services to clients. We are prepared to resist the perpetuation of bigotry by boycotting the 1979 (NDAC) convention . . .' People's Caucus Against Racism and Sexism.

'. . . So long as poverty, discrimination, and unequal opportunity continue to exist in our country, the demand for addiction will continue . . .' Dr Tom Bryant, chairman of the United States President's Commission on Mental Health.

'. . . If this is, in fact, a government as good as its people, then either the people, or the government, or both, are stingy, mean-spirited, and greedy. Given a choice between spending more and taxing less, President Carter and company have chosen the latter, with dire consequences for those who hope for some assistance to solve the great human problems of our time . . .' United States Senator (Georgia) Julian Bond.

'. . . I think the time has come for drug abuse professionals to deal with a larger target population rather than the small minority who abuse the 'bad drugs' . . .' Ron Gaetano, co-chairperson, National Aging Task Force in the United States.

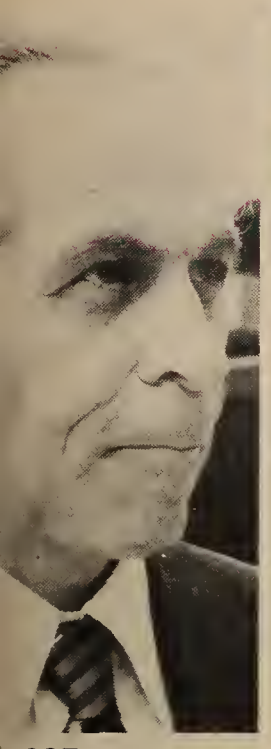
'. . . As I end in discussing broad federal policy, it is important to remember that for me all of this relates back to a simple goal — that of reducing the pain, anguish, and suffering that drug abuse afflicts on so many individuals and families throughout the country . . .' Lee Dogoloff, associate director of the United States Domestic Policy Staff.

June

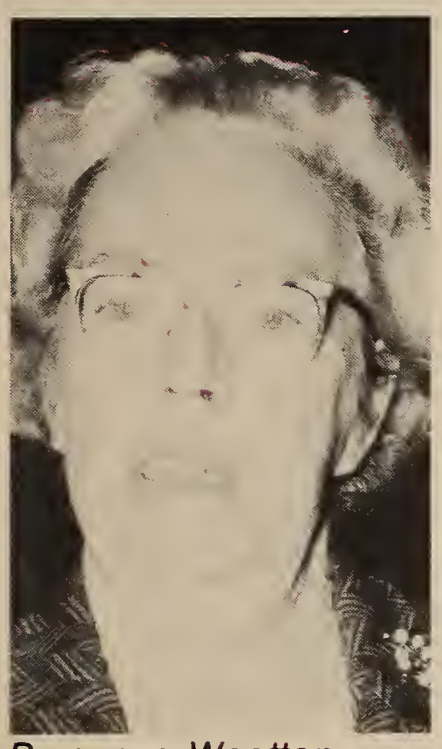
'. . . Learning to deal with one's sexuality can be an important step in creating a new, more confident self who can learn to cope in a chemical-free world. Sex therapy for recovering alcoholics offers an excellent opportunity to begin building self-esteem, which is an initial step in rebuilding lifestyle that has been grossly damaged by alcohol. It can serve as a unifying force for a couple that has not had the experience of working together as a loving team for quite some time, and it can reinforce sobriety . . .' Dr Janet Dowsling, coordinator, medical services, The Donwood Institute.

'. . . I think women were brought into the world to bear children . . . any woman who

...d it in '78



...zasz



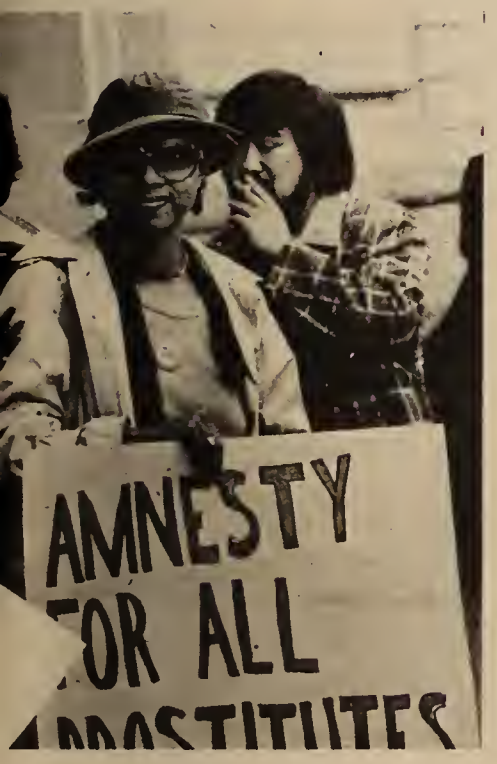
Baroness Wootton



Everett Chalmers



Joseph Califano



decides somewhere along the line that she wants to make a life's career, that's all right, but let her forget the marriage ceremony and go out and do her bit. If she wants to raise children . . . I think it's her duty to stay at home . . .' Dr Everett Chalmers, chairman-designate, New Brunswick Alcoholism and Drug Dependency Commission.

'. . . The only way a person can be sure his or her marijuana hasn't been poisoned by United States' tax dollars is to grow their own . . .' Gordon Brownell, West Coast director, National Organization for the Reform of Marijuana Laws.

July

'. . . What we're going to have is the most humane and probably the most comprehensive (addict treatment) program ever tried in North America. This is not a concentration camp we're setting up; we're not reverting to Nazi Germany . . .' British Columbia Health Minister Robert McClelland.

'. . . Whatever the effect of advertising on consumption in other consumer goods markets, in the case of cigarettes there is a nil correlation between total advertising and total consumption . . .' Rex van Rossum, marketing director, Carreras Rothmans (UK) Ltd.

'. . . To reduce the penalties for the possession, sale, or supply of cannabis, would be bound to lead people to think that the government takes a less than serious view of the effects of drug-taking. This is not so. It would be entirely contrary to government policy to allow this impression to spread . . .' Baroness Wootton of Abinger, chairman Advisory Committee on Drug Dependence, UK.

'. . . (The old idea) that you changed people's attitudes by preaching about the demon rum and how sinful it is (doesn't work). Sin has never been all that unpopular anyhow . . .' Dr Ernest Noble, director of the United States National Institute on Alcohol Abuse and Alcoholism.

August

'. . . Surely, the mere numerical size of the problem has now reached such dimensions that female alcoholics have to be approached as an independent entity and not merely as a relatively insignificant appendage to their male counterparts . . .' Dr Max Glatt, British psychiatrist.

'. . . We are always told that there are two things which can get a cop in trouble, and they are both free: booze and broads . . .' a veteran officer of the Washington, DC police department.

'. . . I think everybody today realizes the hazards (of smoking). There are very few people who are unaware of this. The reason people don't stop is the human frailty of thinking it can't happen to us. We drive too fast. We know it's dangerous. We do things we do because we think we're immune. We know it's bad. We think it can't happen to us, but it can happen to us, and it will happen to us, if we continue . . .' Dr Alton Oschner, founder, the Oschner Clinic, New Orleans.

'. . . And a doctor with a drug, alcohol, or emotional problem tends to gravitate to the geographic periphery, maybe because the cut and thrust of economic competition is too tough in urban areas, maybe because patients have drifted off because he's often not available, or maybe because he's having trouble with hospital privileges. On the periphery, he's unmolested, and he has a captive audience . . .' Dr J. A. Hutchinson, Vancouver, registrar of the British Columbia College of Physicians and Surgeons.

September

'. . . Since rights violations are the result of a failure of society to provide for social responsibilities, the clients rights issue is not fundamentally a legal question but a social one — it should be a movement, a sentiment not to promulgate unworkable blanket legislation, but to press society to fulfill its human and moral obligations to safeguard and improve the rights, needs, and well-being of all of the population . . .' M. Ellen Moffet, executive director, Gaudenzia (therapeutic community), Philadelphia.

October

'. . . Drugs do not cause crime any more than religion causes crime, or television causes crime. If people kill or steal they are criminals, regardless of whether or not they are on drugs. Drug-related crimes are now so common because drugs are prohibited. Crime is now being manufactured by drug prohibition just as it was in the 1920s by (alcohol) prohibition in the United States . . .' Dr Thomas Szasz, professor of psychiatry, New York University, Syracuse.

November

'. . . Staff in alcohol and drug abuse treatment agencies have found it is only in the emotional intensity of dealing with extreme and tragic problems that they experience intimacy and feeling. Many may have had difficulties experiencing and maintaining personal intimacy away from the profession, particularly in relationships which are sexual . . .' William White, National Training System, Des Plaines, Iowa.

'. . . I do believe it is time the substance abuse field acknowledges that some substance abusers, after being treated, are able to lead sober and self-fulfilling lives while drinking and/or using drugs in a non-abusive manner . . .' Dr Jerome Carroll, Eagleville, Pennsylvania.

December

'. . . A non-sex offender may be able to entertain deviant sexual fantasies without acting them out, but it is very dangerous for a sex offender to encourage or allow his mind to dwell on deviant sexual fantasies. If the sex-offender drinks or takes other mind-altering drugs, he may lose control not only of his thoughts and fantasies, but also his ability to control his behavior . . .' Dr Florence L. Nichols, Abbotsford BC.



Cocaine



Growing evidence, mainly from South America, of psychological damage from persistent cocaine use, was the major factor in development of a cocaine strategy by the United States government this year which reflected a dramatic change in thinking.

The strategy was drawn up by Dr Peter Bourne and Lee Dogoloff of the White House staff and was aimed at keeping the price of cocaine high to prevent a significant increase in its use and consequent health damage.

It was estimated some four million Americans used cocaine in 1977 and there were from 100 to 150 deaths associated with use of the drug.

Top priority was given to Peru and Bolivia to help them fight trafficking — estimated at $3.3 billion a year — and to phase out cultivation of the coca plant.

Clinical evidenee from Bolivia and Peru by medical researchers showed severe health consequences especially among those who smoke crude cocaine paste mixed with tobacco or marijuana.

The policy statement said: "It must be understood that the critical factor underlying the apparent lack of severe health consequenees in the US is the high price of the drug, which reflects its relative searcity, and restriets the general level of extent of use.

"The recent attention that cocaine has received in the media is of great concern, as is the advertising of the cocaine paraphernalia: the gold razor blade, the faney coke spoon."

The policy statement showed how much the thinking had changed since 1973. A report then estimated there were no deaths from cocaine use in the US and the drug was almost never used on its own.

Now, it was estimated some 75 deaths a year were due to cocaine use alone. Available evidence was that 10% of users use it daily; 10% use it every weekend which constitutes three days; 10% two weeks a month; 10% one weekend a month; 30% two days a month, and 30% once every two months.

There was no intention of changing current penaltics for simple possession of cocaine.

Oriana Kalant, who spent four years studying the literature in several languages on cocaine, pointed out in an article for **The Journal** in April that the dependence-producing liability of cocaine is fully consistent with experimental evidence in animals.

Dr Kalant, a scientist with the research division of the Addiction Research Foundation of Ontario, said: "Experiments in rats and monkeys trained in self-administering drugs intravenously, shows that cocaine and amphetamines are the most powerful dependence producing drugs. Even more so that morphine."

The International Narcotics Control Board in a report to the United Nations Commission on Narcotic Drugs said there was an increasing amount of cocaine traffic in Europe. The board called for vigorous measures to combat trafficking from South America.

Tobacco



The most important prevention program in the United States today should be directed at smoking. "We have identified it as Ameriea's preventable publie health enemy number one," said Joseph Califano, seeretary of Health, Education, and Welfare.

In his report to Congress, on the health consequenees of smoking (**The Journal**, Sept) Mr Califano pointed out that the latest research data shows women are adopting smoking habits like those of men and suffering the consequenees.

Mr Califano said the data "confirms that women smokers indeed have come a long way 'baby' and a long way towards higher disease and death rates from bronchitis, emphyzema, lung cancer, certain other cancers, and cardiovascular disease.

"Since 1950, the death rate from lung caneer among men aged 45 to 64 has more than doubled. But among women it has quadrupled. Seventy-five percent of heart attacks among women under age 45 eould be avoided if women did not smoke."

In Canada, research at seven Ontario medieal eentres showed that post coronary care patients who continue to smoke run an extremely high risk of second, and fatal infarction.

John Sutton, of the cardiovascular unit, McMaster University, Hamilton, Ontario, said that among 751 men enrolled in the program since it began in 1972, "almost all of the mortality so far has been among men who have continued to smoke. We don't know yet how significant that is but it is a trend and it has a lot of implications."

Dr Sutton added: "I think the highly significant data we have on smoking, even though it is preliminary, makes a doctor morally bound to emphasize more than ever the dangers of smoking."

Meanwhile, some areas have adopted laws banning smoking in public areas while efforts to curb smoking in two areas — California, and Washington, DC — eame to nothing.

In November balloting, California voters turned down a proposal to ban smoking in public buildings. The tobacco industry was reputed to have put $5 million into the campaign against the proposition.

In Washington, the city council was set to enact a draconian anti-smoking bill when a lobbyist waltzed into town and, within two weeks, convinced the majority of members such an amendment would be bad for the city's image.

Heroin



The estimated number of heroin addicts in the United States has dropped by some 100,000 — from 550,000 to 450,000 — over the past three years, according to federal estimates.

Lee Dogoloff, head of the White House Drug Policy Office, said the estimate made by the National Institute on Drug Abuse is based on three years of consistently declining national heroin indicators.

Mr Dogoloff said: "From July of 1976, the number of heroin-related deaths has decreased by more than half. Emergency room injuries have also reduced by half in the same period.

"The average retail price of heroin has increased by nearly 20% while the average purity has decreased by more than 20%. The number of heroin admissions has declined, treatment has deelined, the percent of heroin admissions has declined, and the percent of new heroin admissions has declined substantially."

Marijuana



Marijuana moved more into the medical research field in 1978 with several states authorizing use of its derivatives for glaucoma patients and for those suffering from the ill effects of chemotherapy used in caneer treatment.

Various state agencies will work through the National Institute on Drug Abuse (NIDA) and the Food and Drug Administration (FDA), whieh gives final approval for any experimental drug trials.

Two cannabis derivatives, delta 9 tetrahydrocannabinol and cannabidiol, were rescheduled for research purposes by the controlled substance advisory committee of the FDA. The rescheduling classified the derivatives as having abuse potential but also possible therapeutic benefits.

The committee refused to resehedule cannabis and all of its derivatives.

As for marijuana use among the general population, the "paraquat" scare generated early in the year gradually abated. At first it was thought marijuana tainted with the herbicide was being smuggled from Mexico and posed a serious health hazard to smokers.

Tests showed only a small amount of paraquat-tainted marijuana was, in faet, reaching the American market.

The latest study released by (NIDA) said that no case of human poisoning from paraquat-contaminated marijuana had been confirmed.

Tests by NIDA's scientists led to the conclusion that if a person smoked five marijuana cigarettes every day for one year, and each cigarette contained 500 parts per million of paraquat, permanent lung fibrosis (reduced capacity to absorb oxygen) could develop.

The report went on to point out, however, that the condensed smoke of marijuana not contaminated with paraquat, contains a higher percentage of cancer-causing agents than tobacco.

Marijuana's capacity to damage lung tissue was also demonstrated in the latest research report — there were significant changes of lung function in 74 men who smoked an average of five marijuana cigarettes a week for at least two years.

The damage was greater than among a matched control group who did not use marijuana but smoked an average of 16 or more cigarettes a day, according to the findings by Donald Tashkin, associate professor of medicine at the University of California, Los Angeles.

Dr Tashkin said he did not know if the effeets of the marijuana smoking were permanent or would lead to significant disease. However, he said, "no one should be lulled into a false sense of security that smoking marijuana regularly, at least three times a week, is without any harmful effects on the lungs."

In Britain, a random survey eondueted by scientists from the University of Surrey and the home office forensic seientific laboratory showed cannabis may be a signifieant faetor in road deaths there.

Tests were carried out on the bodies of 54 motorists and 12 motorcyclists killed during a 10-month period in 1977 and 10 of these were found to have been using the drug.

A study among American high sehool students found that 56% of the seniors reported having used marijuana at least onee. Some 9% reported daily use.

Widespread use of marijuana and its derivatives was reported among US servicemen, primarily those aged 18 to 25. Witnesses at sessions of the House of Representatives sub-committee on narcotics abuse indieated use was particularly high among front-line troops in Europe and the Far East.

Marijuana also was worrying the Canadian Armed Forees. Lieutenant General J. C. Smith, assistant deputy defence minister, said its use was an increasing problem. "There seems to be a correlation between the very new recruit just out of high school and the incidence of marijuana use," he said.

American parents should take a less nonchalant attitude to the use of marijuana by their children. That was the message from Lee Dogoloff, director of the White House Drug Policy staff.

"The 'it's only marijuana' concept must be changed and this is a challenge for the future," he said.

In the courts, three US federal court judges were studying expert scientific evidence on marijuana, which will be the basis for a ruling next year on the constitutionality of federal marijuana laws. The hearing was a result of a suit brought by the National Organization for the Reform of Marijuana Laws.



The eclectic Wayne Howell

Here it is, almost the end of the year, and I still have some stray letters from readers lying around unanswered. Rather than commit my replies to the tender mercies of the Post Office in its post-strike/pre-Christmas phase, I am publishing them here, hoping the individuals concerned will see them. The first letter is to Mr E. B. Stoddard, Dorchester, New Brunswick.

Dear Mr Stoddard:

With all due respect, I believe you are somewhat confused. 'Amotivational syndrome' is a term used to describe certain alleged effects of marijuana smoking. Technically it is incorrect to say that federal politicians who are dragging their heels on the bill to decriminalize marijuana suffer from this syndrome. Feel free to apply other labels to them, however.

The second reply is to a Colonel R. A. Staghorn, Calgary, Alberta.

Dear Colonel Staghorn:

Yes, I am familiar with "Wine is Our Best Medicine", the surprise best seller by Dr Emerick Maury, the French doctor who drinks a litre of wine a day and recommends Medoc for allergies, Sancerre for gallstones, and Beanjolais for diabetes. And I am pleased that you have found the Maury regimen has increased your vitality and alleviated your various afflictions. I do believe, however, that you overstate the case for the Maury regimen when you suggest that because you can feel your liver below your right costal margin this is proof that your internal organs are becoming more robust and muscular.

This is in reply to a letter from Mrs J. O. Brown, Victoria, British Columbia.

Dear Mrs Brown:

In reply to your inquiry re the difference between the War Measures Act and the new British Columbia act for the compulsory treatment of heroin addicts. Quite simply, the difference is this: under the former act a person can be held against his will indefinitely; under the latter act he can only be held against his will for one thousand and ninety five days.

This letter is for Mrs J. I. Thorpe, of London, Ontario.

Dear Mrs Thorpe:

I have, on your behalf, made inquiries at Health and Welfare Canada. Here is your answer: officials refuse to confirm or deny that they are going to compile a list of those persons whose names are to be deleted from Bureau of Dangerous Drugs File No 14086 because their names were just placed there on hearsay — they were never convicted of any drug offence. However, they do say that if they do make a list of names deleted from the other secret file, the new list will be secret. I hope this sets your mind at ease.

And for Mr W. B. Twillingham, of Hamilton, Ontario.

Dear Mr Twillingham:

Yes, I have heard that Frank Drea, Ontario's new minister of Consumer and Corporate Affairs, plans to force topless waitresses in Ontario bars to cover up, and is also considering changing the law so that alcoholic beverages can be served on trains and buses. And if these things do come to pass, I assure you I will pass on your headline suggestion to Anne MacLennan, the editor of **The Journal**. *I must say, DREA NIXES NIPPLES: TRAVELLERS TO TIPPLE, has a certain alliterative appeal, but I am not the one to make the final decision.*

Ed's note: Dear Wayne: If you and Mr Drea will promise to stop trying to get your headlines published, I promise that we here will keep you both in mind next time we're having any real trouble with one. In the meantime, you make a great Ottawa physician, freelance writer, and regular contributor, as a columnist, to The Journal. Happy Holidays. Anne.

...And here's the team for '79



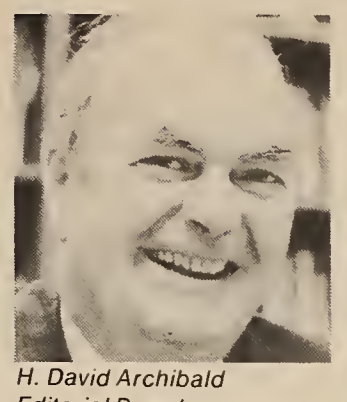
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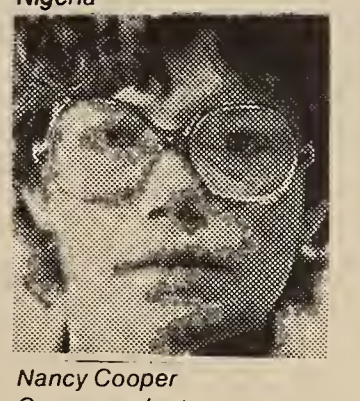
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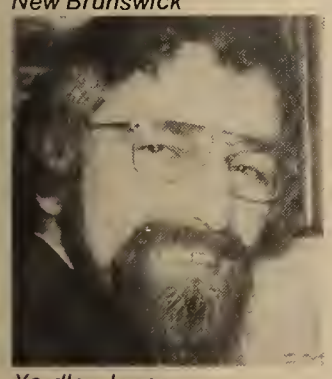
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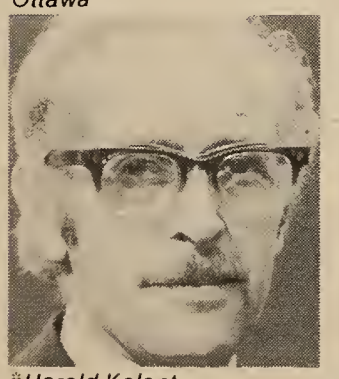
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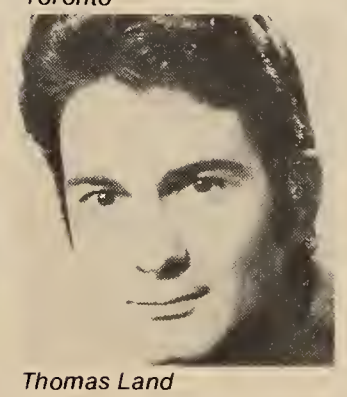
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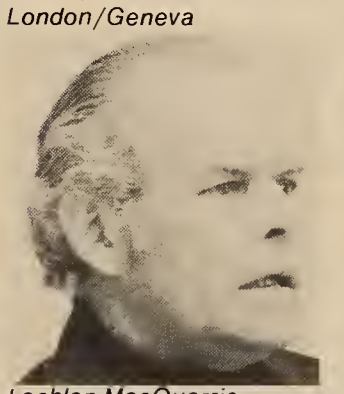
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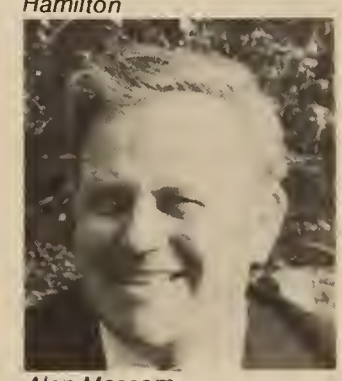
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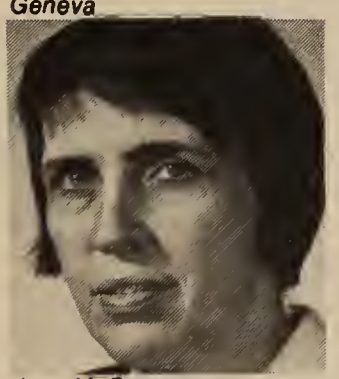
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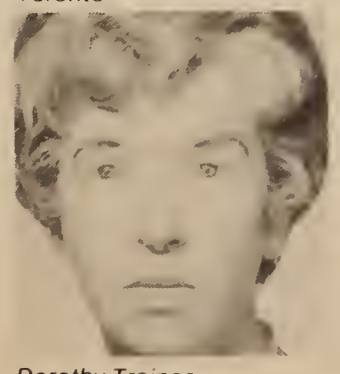
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MDs warned on dangers of benzodiazepines

By Alan Massam

LONDON — An educational campaign to make doctors appreciate the dangers of their present scale of use of benzodiazepines is "urgently needed," according to a leading psychopharmacologist.

Malcolm Lader, Institute of Psychiatry, London, believes the tranquillizers should be reserved for severely anxious patients who really need them.

The less specific stress responses should be managed by non-pharmacological means, such as adequate and experienced counselling, he says.

To date, the benzodiazepines seemed safe drugs, astonishingly non-toxic in overdose, but the symptomatic treatment of stress reactions had social implications.

"It could be argued that the appropriate treatment is to lessen the social problems by social reforms," Dr Lader said.

"Instead, the individual is persuaded to tolerate his conditions. With pharmacological help his responses are attenuated. The Orwellian spectre of chemical manipulation of the populace can be seen to be uncomfortably real.

"In cost effective terms, tranquillizers are cheap. It is much cheaper to tranquillize distraught housewives living in isolation in tower blocks with nowhere for their children to play, than to demolish these blocks and rebuild on a human scale, or even to provide play groups.

"The drug industry, the government, the pharmacist, the taxpayer, and the doctor all have vested interest in medicalizing socially-determined stress responses. As the doctor is crucial to this process, he is at the point at which reform is most appropriate."

Dr Lader made these points at a recent meeting of medical journalists after completing a south London study attempting to link self-reported anxiety levels and tranquillizer use among adults.

A sample of slightly more than 1,000 adults was interviewed, and about 650 were persuaded to complete the Salkind Morbid Anxiety Inventory (MAI).

The study found neither sex nor age were related to MAI scores, but manual workers tended to be the most anxious, followed by professional workers.

Neither marital status nor social mobility related to the scores, but Catholics and Jews tended to be more anxious than the average. Male smokers tended to be more anxious than non-smokers and alcohol intake appeared to be unrelated to anxiety levels (possibly a reflection of under-reporting of alcohol consumption.)

About one third of the females interviewed and one fifth of the males had had recourse to tranquillizers at some time, while 8% of males and 14% of females had taken them in the previous year.

About 3% of the males and 5% of the females had used them for more than six months during the previous year.

Use of tranquillizers was clearly related to the MAI scores, especially in the women. Usage was greatest in women aged 25 to 44 — nearly half of the sample in this group having taken the drugs.

Dr Lader said it appeared that when patients came to their doctors with symptoms related to stress, the response was to "medicalize" the problem by concentrating on the symptom rather than the cause.

Doctors' training led them to deal with symptoms rather than predominantly social factors, but by writing prescriptions they were reinforcing the patient's belief there was something medically wrong.

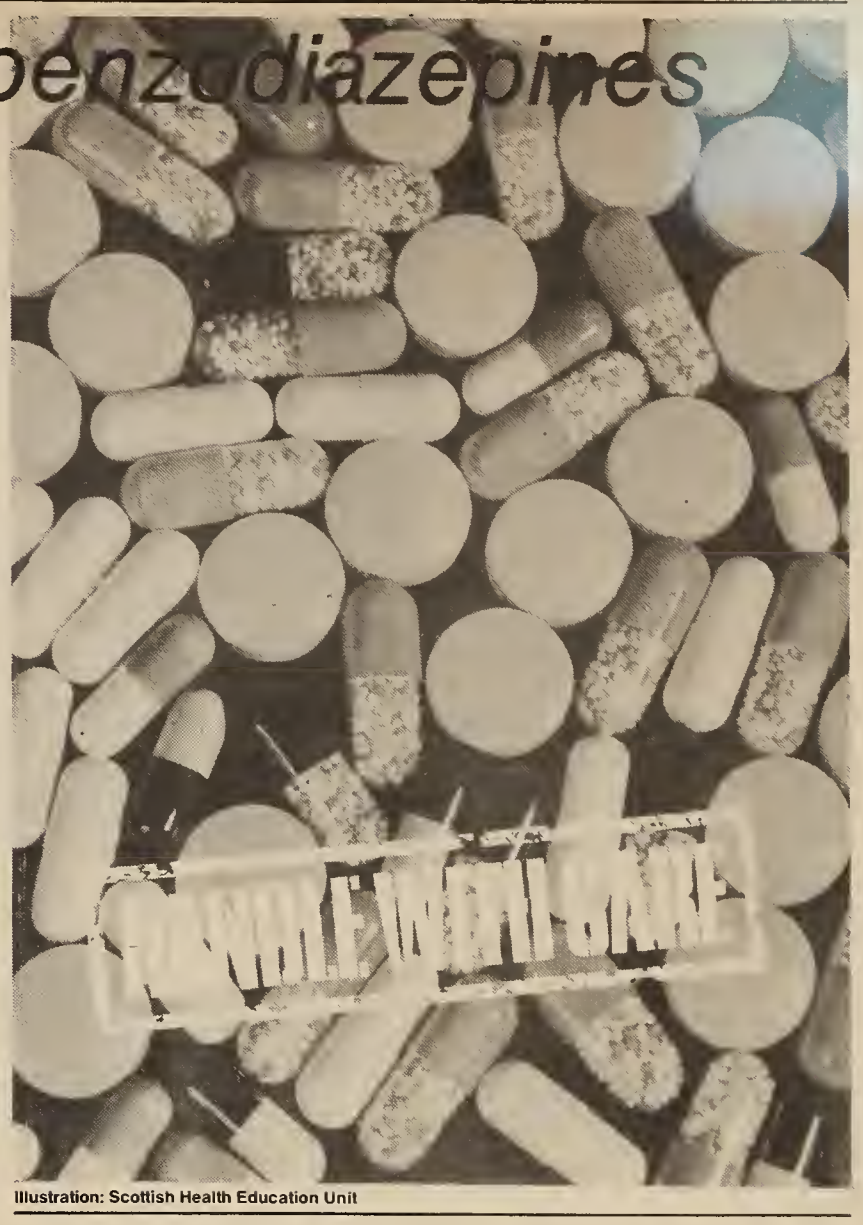


Illustration: Scottish Health Education Unit

Beating addiction the holy, happy, healthy way

TUCSON — Yoga, a vegetarian and fruit diet, body massage, medication, exercise, and vocation counselling. These are some of the tenets of the 3H0 drug program here which claims more than a 50% success rate with alcohol and drug clients.

The program has also received approval from the Joint Committee on Accreditation of Hospitals, the first therapeutic community in the country to be so accredited, according to research development director Sadhu Singh Khalsa.

The success rate would probably be even higher with clients, he added, except "we are the only therapeutic drug program in the state that takes clients with serious mental health problems. Many of our most difficult clients have been characterized as schizophrenic, psychotic, sociopathic.

"Secondly, we have the strictest rules of any program in the country. We do not allow any smoking, drinking, or sexual behavior of any kind. If we were as lenient as other programs that did not take in clients for such histories of psychiatric treatment, our retention rate would be much higher."

Mr Khalsa said that while the program is strict "the philosophy is that clients with drug problems are not an inferior group. We all have problems at different times and in different areas."

Clients are treated with respect, dignity, and equality. "All of the counsellors of our program are totally drug free, even of cigarettes."

The 3H0 philosophy is based on the belief that natural healing techniques such as kundalini yoga, meditation, special diets, hydrotherapy, and massage utilized within a structured environment are the most effective means to treat people with drug and alcohol problems.

Mr Khalsa said this is not meant to criticize "talking therapies" or people with good intentions. "It is however, to suggest that one cannot effectively treat addiction with the use of another drug or by just talking to a person who hurts. One must be able to help the person to become self-healing by teaching that person how to do it and to maintain oneself without the use or abuse of drugs."

The method employs a holistic systems approach to treatment, centred on the 3H0 style of living.

The aim of the program is firm transition of clients back to the general community. Although more than 300 people have passed through the program since it began in 1972, only two clients have chosen to live the full 3H0 way of life.

Mr Khalsa said that providing a behavior model is vital to success.

He explained: "The clients never see the counsellors, administrative staff, or board personnel using or selling drugs, stealing, lying, exploiting other people, or hustling men or women.

Nations join to fight drugs at source

By Thomas Land

GENEVA — The end of the Vietnam War has brought about a crucial change in the market forces affecting the illicit international trade in narcotics. The result is a common interest shared by the producer and the consumer countries to suppress the trade at source.

Australia has announced its decision to contribute $200,000 this year and $400,000 a year in subsequent years to 1981 from funds earmarked for overseas development assistance to finance crop substitution projects in Asia. New Zealand is about to follow suit. The United States is making a $3m contribution this year. Britain and Canada are already involved in Asian projects funded from development aid finance intended to cut down opium poppy cultivation.

They all follow Northern Europe's first major, practical response to the challenge of drug traffickers, made by Norway last year when it announced a multi-million dollar backing for a crop substitution and public health and development project to be implemented in Burma.

Burma, a major opium producer of the notorious Golden Triangle, has met the Scandinavians half way with its own anti-narcotics project. It has a pressing reason to do so. For the end of the American involvement in Vietnam has also wound up the rich Asian market for opium. And Burma, where clandestine laboratories were soon established by the narcotics rings to supply the domestic market for heroin, now had to face drug addiction at home on a hitherto unknown scale.

This year, more than 5,700 hectares of Burmese poppy fields have been put to alternative crops, such as rice and wheat, reducing the illicit national opium crop by something like 35 tons, according to the United Nations Food and Agriculture Organization.

The scheme, still in its early stages, is conducted with technical assistance from the UN Division of Narcotic Drugs and with financial aid through the UN Fund for Drug Abuse Control.

During its first four years of existence, the UN fund received $15m from the United States, $606,000 from Canada, and $355,000 from Britain as well as small token donations from other countries. Norway last year became the second biggest donor with a commitment of $5.4m, bringing the weight of its entire contribution to bear against the traffickers in Burma because their country is the world's biggest individual producers of raw materials used in illicit heroin.

The other members of the Nordic Council have followed Norway's example. And they have also urged prosperous countries elsewhere to join them in a generous and rational approach to eliminating the supply of illicit drugs by providing opium poppy growers with an acceptable alternative means of livelihood.

Dr Bror Rexed, executive director of the UN fund here, has just been informed of Australia's decision to release funds for that purpose from the budget of the national Development Assistance Bureau. A similar announcement is expected in the immediate future from New Zealand.

The international schemes enjoy the support of the White House in the United States. Announcing America's latest financial contribution to the UN fund, President Jimmy Carter recently declared in Washington that "drug problems cannot be solved unilaterally, but require concentrated attention by the world community. Drug abuse is exacting an ever greater toll on the citizens of the developed and the developing countries. It affects our economies, our societies and — most important — our culture."

The Nordic initiative was the first major, practical response to the challenge of Chinese heroin traffickers who have replaced the famous French Connection by capturing the wealthy drug markets of Western Europe. Their principal source of supply has been the Golden Triangle comprising parts of Burma, Thailand, and Laos and producing about 500 to 600 tons of opium a year.

The UN/Burma program for drug abuse control began officially in May, 1976, with the signing of a formal agreement covering agriculture, health, social welfare, and education, and designed to curb illicit opium production and local drug abuse. A similar scheme is operated with much success and with technical assistance from Canada and Britain in neighboring Thailand.

Norway expects its initiative to lead to increased and coordinated international efforts to reduce illicit poppy cultivation and to encourage food production in the region of crop substitution. Such projects in the past were financed from strictly limited funds but, as a Norwegian government spokesman recently put it, a better use of development aid funds can hardly be found.

Evidence in on EAPs

TORONTO — Employee Assistance Programs (EAPs) for workers with alcohol and drug related problems frequently are "highly successful", says an Ontario task force report

The report by the Addiction Research Foundation of Ontario's Task Force on Employee Assistance Programs indicates success rates can be as high as 65% to 80%. Yet the ARF's 37 Toronto and regional centres report only 348 organizations employing 8% of Ontario's work force have programs for their employees with alcohol and drug related problems.

The task force, headed by Donald Smith, regional director, central west region, ARF, Hamilton, says EAPs should be encouraged, but notes success rates should be viewed with caution.

"The weight of the evidence suggests with some vigor that EAPs are relatively effective methods of averting the common climax of the identified alcoholic's drinking career, namely, the disintegration of personal, familial, interpersonal, and financial resources."

But, "it should be taken into account that employed clients are in a better position to meet the success criterion of restored satisfactory job performance than are patients who have lost their jobs and must go through the additional step towards recovery of securing new employment.

"Until very recently, the evidence for the success of EAPs was restricted mainly to measurements of the client's job performance."

Yukon sobers up on public drinking

WHITEHORSE — The rough and ready, hard-drinking Yukoner is fading into the history books — as is the notion that *all* northerners must have drinking problems.

Yet in the Yukon, laws pertaining to the consumption of liquor remain among the most lenient in Canada. For example, it is legal to drink anywhere in public, even while driving.

Bill Cline, the director of drug and alcohol services for the Yukon Territory, believes while liberal liquor laws may not influence alcoholism directly, they can affect people's attitudes to alcohol and the problems that result.

For this reason alone, more Yukon communities should be taking steps to ban public drinking, he says.

Mr Cline says there has been a noticeable change in the problem of public drinking related to a change in the make-up of the population in recent years.

"The myth of the northerner who's tough and loud and who flaunts his booze no longer sits well with the average northerner.

"Our population is changing. People of all segments of society in the north want equal access to anything that's in the south. They're more career-conscious, for example. And they take life more seriously."

One result is that public drinking is no longer such a serious problem.

More often now public drinking is "a case of young people and tourists who think it's fun to show off their booze," Mr Cline said.

One study by the Yukon's Alcohol and Drug Services concluded Yukoners, with the exception of those few who drink to excess, consume alcohol like any other Canadians. According to Mr Cline, most people in the Yukon (as elsewhere) drink very little.



Yukon communities such as Dawson City (above) continue the debate on public drinking laws. Although alcoholism is decreasing there, it is still legal to drink in public — even while driving.

Yet, Mr Cline believes more Yukon communities should act on the local option to prohibit public drinking.

(Liquor laws are a subject of almost constant debate in the Yukon. Recently, the Yukon Territorial Council was under pressure to amend the public drinking section of the liquor ordinance in order to make public drinking illegal.

The Council's response was to allow for a local option, whereby each community in the Territory would have the power to ban public drinking.

Mr Cline said only Dawson City acted on the option — and it did so only to stop tourists from littering beer bottles in the streets during the summer months and, in particular, during the rowdy Discovery Day holiday celebration in August.)

How people handle their liquor influences just how seriously young people treat alcohol, says Mr Cline.

"I think the most important thing in talking about this subject is that we cannot go to the extreme.

"People have to take our laws seriously. Liquor laws, more than anything, set a tenor, a seriousness about using alcohol."

Mr Cline warns if the Yukon experiences a sudden population boom, perhaps as a result of the northern gas pipeline project, public drinking could become a much wider problem.

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Will US drinks be spiked with thiamine?

NEW YORK — Wernicke-Korsakoff psychosis is a thiamine deficiency disorder striking a small number of alcoholics. But the idea of adding thiamine to alcoholic beverages brings few hurrahs in the United States.

Dr Michael H. Criqui, assistant professor of community medicine at University of California, San Diego, says, however, that adding thiamine to liquor, beer, and wine would save from $53 million to $67 million in long term institutionalization costs in the US.

Using rates of first admissions to New York psychiatric centres from 1961 to 1970, he and colleague Brandon S. Centerwall (a medical student) estimate (*New England Journal of Medicine*, Aug 10, 78) the prevalence of long term care for the syndrome at three per 100,000 adults, resulting in costs of $70 million/year to treat the attendant ophthalmoplegia, and progressive dementia.

The untreated syndrome leads to coma and death.

The suggestion thiamine be added to alcoholic beverages is not new, but this time it came packaged with a cost-benefit analysis.

Nevertheless, the $25-billion/year US liquor industry expressed cautious disdain for the idea, adding that it's not as simple as adding something to water.

Industry organizations say they couldn't promote the addition anyway because alcohol beverage labelling and advertising are prohibited by US law from referring to therapeutic qualities, including vitamin content, in their products.

The Distilled Spirits Council of the US said prevention of the syndrome in this manner might offer false hopes to alcoholics that they might also be spared other far more common effects of alcoholism.

The suggestion that alcoholics simply take thiamine pills as an adjunct to drinking was dismissed by Dr Criqui because compliance rates are not good with alcoholics.

By adding thiamine directly, compliance would be 100%, he said.

CBA wants decrim of cannabis

By Jeff Carruthers

OTTAWA — The Canadian Bar Association has formally taken its proposal to decriminalize certain cannabis crimes to the federal government.

But Thomas Walsh, the Calgary president of the 23,000-strong lawyers' organization, came away from the meeting with Justice Minister Otto Lang feeling that the coming federal election will prevent any legislative action to ease cannabis penalties.

Mr Walsh told reporters, after the closed-door meeting with Mr Lang: "I would like to see the marijuana situation looked at now." He said Mr Lang didn't comment on the CBA's proposal too openly.

In a resolution passed at the 1978 national meeting, the Canadian Bar Association recommended the "decriminalization" of:

- simple possession and cultivation of cannabis for an adult's own use; and
- the non-profit transfer of small amounts of cannabis between adult users.

The CBA also recommended that cannabis be transferred from the Narcotic Control Act and be placed under Schedule G of the Food and Drug Act.

Both the Liberal and Conservative parties in Ottawa claim to want the cannabis legal situation changed as quickly as possible. However, both also hedge their position by noting there are other higher-priority legislative items which must be dealt with first, even after the next federal election.

The federal Liberal government promised some six years ago to ease penalties for most cannabis crimes; one piece of legislation actually was approved by the Senate, but never received the necessary approval of the House of Commons.

PQ may face smoking laws

MONTREAL — The Quebec government is considering a law to limit smoking in public places — similar to Toronto and Ottawa regulations.

It would decree no smoking in auditoriums, sport centres, elevators, school buses, and elementary schools and smoking only in certain enclosed areas of universities, hospitals, restaurants, foodstores, junior colleges, and high schools.

Pierre Montambault, a member of the social affairs ministry task force which prepared the recommendations said the suggestions have received favorable reception "even from chain-smoking members of the cabinet."

The new law may be introduced next summer and would be part of a full-scale battle against the province's estimated 3,000,000 smokers. The government is also considering a total ban on cigarette advertising, restrictions on the sale of tobacco products in public places, and firmer restrictions on tar and nicotine levels in cigarettes.

More tar in third world

LONDON — Tobacco consumption is growing fastest in the developing countries of the world — thus setting the scene for "tomorrow's epidemic" of smoking-related diseases.

That is the message incorporated in the title of a hard-hitting criticism of the export efforts of the developed world's tobacco companies, just published by the British charity War on Want*.

Author Mike Muller claims some cigarettes sold in Third World countries contain twice as much cancer-causing tar as the same brands sold in developed countries — "so the smokers with the least information about smoking hazards are put most at risk." He quotes a spokesman for one large company saying the third world smoker consumes only a few cigarettes every day, and therefore needs a stronger one.

He recommends third world governments should take action to discourage their populations from smoking.

**Tobacco and the Third World: Tomorrow's Epidemic. War on Want, 467, Caledonian Rd, London N.7.£1.20.*

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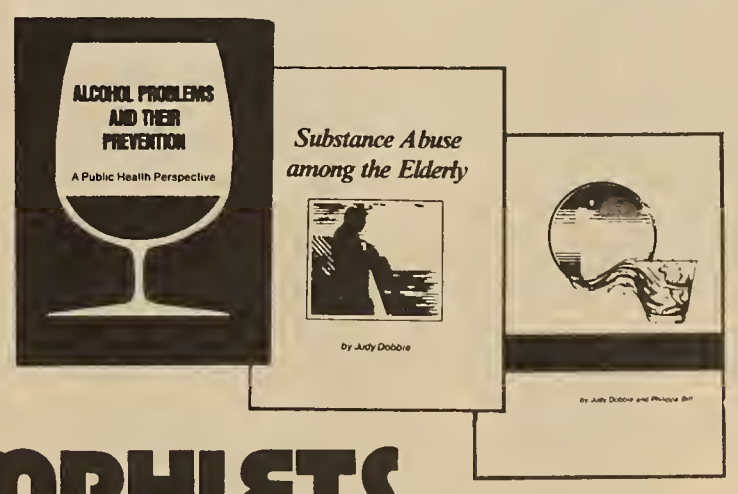
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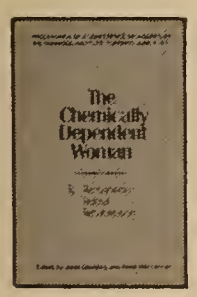
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New Books

by RON HALL

Behavioral Treatment Of Alcohol Problems: Individualized Therapy And Controlled Drinking

. . . by Mark B. Sobell, and Linda C. Sobell

Of particular use to individuals who have an interest in behavior therapy, and those who are interested in the treatment and treatment outcome evaluation of alcohol problems, this book summarizes the authors' clinical research conducted during the past eight years. A perspective on traditional concepts in the alcohol field is followed by a consideration of the rationale, methods, and results of the study of Individualized Behavior Theray (IBT) for alcoholics. Following a discussion of many of the more subtle aspects of that study and its results, the authors describe how IBT can be used in **an outpatient setting. Detailed** information is presented on statistical and behavioral interpretation of results, interviews conducted with subjects two years after the completion of the experiment, and the variables used to predict a successful treatment outcome.

(Plenum Press, 227 West 17th St, New York, New York, 10011. 1978. 240p. $16.95.)

Other Books

A Survey Of Smoking Education Given In Prenatal Classes In Canada — Hayes, D. (?). The Canadian Council on Smoking and Health, Ottawa, 1977. Joint authors — Laurente, S., McRae, B.C., and Choi-lao, T. Appendix. 20p. $1.

Narconon Provides An Effective Solution In Reducing Crime And Drug Abuse — Narconon Rehabilitation Program. L. Ron Hubbard, Toronto, 1978. 90p.

A Study Of Occupational Alcoholism Programs In Canada — **Dexjardins, C. Canadian Addictions Foundation, Vanier, 1977.** Methodology and results of a questionnaire survey of employers. Appendix, bibliography, 22p. $1.25.

The Treatment Of Alcoholics — An Ontario Perspective — Marshman, J.A. (chairman). Addiction Research Foundation, Toronto, 1978. Report of the Task Force on Treatment Services For Alcoholics prepared for the President, ARF. The magnitude of the problem, the current response, the youthful problem drinker, the elderly alcoholic, women, particular cultural groups, references, appendix, bibliography. 22p. $1.25.

Summary Of The Treatment Of Alcoholics: An Ontario Perspective — Marshman, J. A. Addiction Research Foundation, Toronto, 1978. Report of the Task Force On Treatment Services for Alcoholics, prepared for the President, ARF. Recommendations. 30p.

Simulation Study Of The Impact Of Occupational Programs — Schlenger, W. E., Hawyward, B. J., Hallan, J. B. Human Ecology Institute, North Carolina, 1976. Problem drinking among employed persons, model experimental procedures, impact on employees and on organization, economic conditions. Tables. References. 72p. $4.65.

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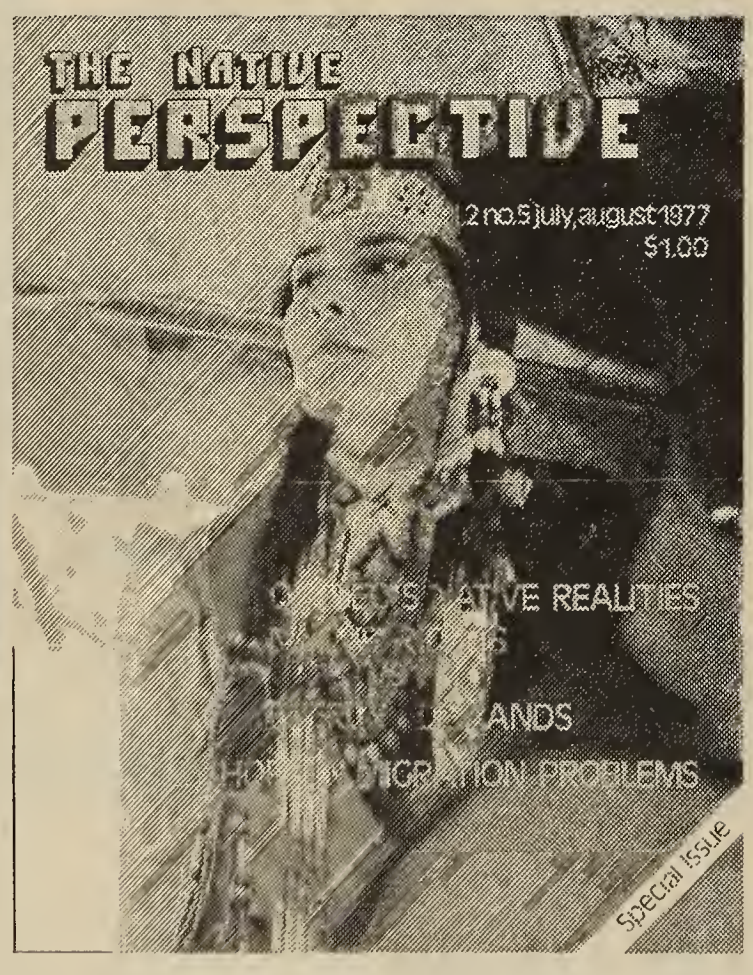
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Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six point scale. For further information, contact Linda Chung, coordinator of the group at (416) 595-6150.

New Beginnings: Women, Alcohol And Recovery

Subject Heading: Women and alcohol.
Details: 23 minutes, 16 mm, color, sound.
Synopsis: Featuring Jan DuPlain, former director of the Office of Women, National Council on Alcoholism, this film attempts to change attitudes and break down stereotyping of female alcoholics. Three recovered female alcoholics relate their experiences with alcohol, and discuss what sobriety means to them. Donna-Marie, a young women recovering from alcohol and drug abuse, finds support and new opportunities as mother, student, and pottery maker. Chaney, a volunteer social worker has written an autobiography, *I'm Black and I'm Sober.* Muriel, a grandmother, has found new meaning in her career and life. All three are optimistic that as the sigma is removed, things will become even better.
General Evaluation: Good (3.8). A contemporary and technically well produced film, it received moderate rating in all other categories. The A/V Group particularly liked what the film said about alcohol and its use, and felt the film suitable for publie broadcast.
Recommended Use: Likely to benefit audiences of 15 years of age and older. Particularly beneficial to women alcoholics, and to groups who tend to stereotype female alcoholics in their dealings with women.

Marijuana: The Facts

Subject Heading: Drugs, pharmacology.
Details: 25 minutes, ¾" U-Matic videocassette, color, sound.
Synopsis: The videotape explains what marijuana is, what it looks like, how it is used, and some of its effects on the body. A group of young people at a pot party ask questions about marijuana which are answered by Dr Harold Kalant, head of Biological Studies, Addiction Research Foundation of Ontario.
General Evaluation: Good (4.3). This videotape was rated as informative and contemporary. Some group members felt the beginning of the tape was overly didactic. The group especially liked the question-answer segment of the tape, and felt it was effective in disseminating factual information.
Recommended Use: Likely to benefit general audiences of 15 years of age and older. May be particularly beneficial to health professionals. A resource person is recommended but not essential.

Dead End

Subject Heading: Skid row.
Details: 7 minutes, 16 mm, color animation.
Synopsis: Through an animation process involving plasticine figures and sets, the film attempts to portray what an alcoholic experiences as he walks down a skid row.
General Evaluation: Poor to fair (2.3). Due to its lack of clarity of message, and lack of information and poor technical quality, this film was deemed a poor teaching aid.
Recommended Use: Of little anticipated use, although it might be used in treatment settings with skid row inhabitants.

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Canada

Detox Training Program — Feb 5-9, March 26-30, April 30-May 4, 1979, Toronto, Ontario. Information: G. Gooding, Assistant to the Coordinator, Detox and Rehab Programs, Addiction Research Foundation, 33 Russell St, Toronto, Ont., M5S 2S1.

70th Annual Conference Of The Canadian Public Health Association — June 18-22, 1979, Winnipeg, Manitoba. Information: Mr G. H. Dafoe, Executive Director, CPHA, 1335 Carling, Suite 210, Ottawa, Ontario, K1Z 8N8.

United States

National Organization For The Reform of Marijuana Laws 7th Annual Conference — Dec 1-3, 1978, Washington, DC. Information: NORML, 2317 M St, NW, Washington, DC, 20037.

Alcoholism — The Search For The Sources — Jan 24-26, 1979, Raleigh, North Carolina. Information: Elaine Woody, Center for Alcohol Studies, University of North Carolina, Chapel Hill, NC, 27514.

International Conference On Treatment Of Addictive Behaviors — Feb 20-24, 1979, Taos, New Mexico. Information: W. R. Miller, PhD, University of New Mexico, Albuquerque, NM, 87131.

Cruising Medical Seminar On Alcoholism — March 2-13, 1979, "Statendam" Sailing from Florida. Information: John A. Ewing, MD, Director, Center for Alcohol Studies, University of North Carolina, Chapel Hill, NC, 27514.

Alabama School Of Alcohol Studies — March 20-23, 1979, Tuscaloosa, Alabama. Information: Peter Balsamo, Director, Continuing Education in Human Services, University of Alabama, PO Box 2967, University, AL, 35486.

American Medical Society On Alcoholism — April 26 - May 2, 1979, Washington, DC. Information: J. G. Chen See, MD, AMSA, 733 Third Ave, New York, NY, 10017.

First National "Women in Crisis" Conference — May 17-19, 1979, New York City. Information: Jane Velez, Conference Administrator, "Women in Crisis", 444 Park Avenue South, New York, NY, 10016.

14th Meeting — Association Of Halfway House Alcoholism Programs — June 3-7, 1979, Lincoln, Nebraska. Information: AHHAP, 786 East 7th Street, St Paul, Minnesota, 55106.

6th National Drug Abuse Conference — Aug 26-30, 1979, New Orleans, Louisiana. Information: NDAC '79, 115 S Chestnut Street, Lafayette, LA, 70501.

4th World Conference Of Therapeutic Communities — September, 1979, New York City. Information: Monsignor WB O'Brien, President, Daytop Village, Inc., 56 West, 40th Street, New York, NY, 10018.

Abroad

International Conference On Animal Models In Alcohol Research — June 4-7, 1979, Helsinki, Finland. Information: John David Sinclair, Research Laboratories of the State Alcohol Monopoly (Alko), Box 350, SF-00101 Helsinki 10, Finland.

25th International Institute On The Prevention And Treatment Of Alcoholism — June 18-22, 1979, Tours, France. Information: International Council on Alcohol and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

Third World Congress Of The International Commission For The Prevention Of Alcoholism And Drug Dependency — Aug 26-31, 1979, Acapulco, Mexico. Information: ICAP Executive Director, 6830 Laurel Street, NW, Washington, DC, 20012.

10th International Conference On Health Education — Sept 2-7, 1979, London, England. Information: The Conference Centre, 43 Charles Street, Mayfair, London W1X 7PB, England.

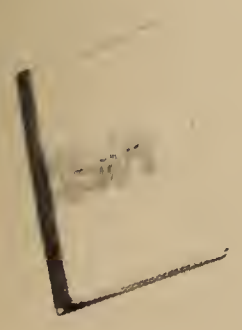
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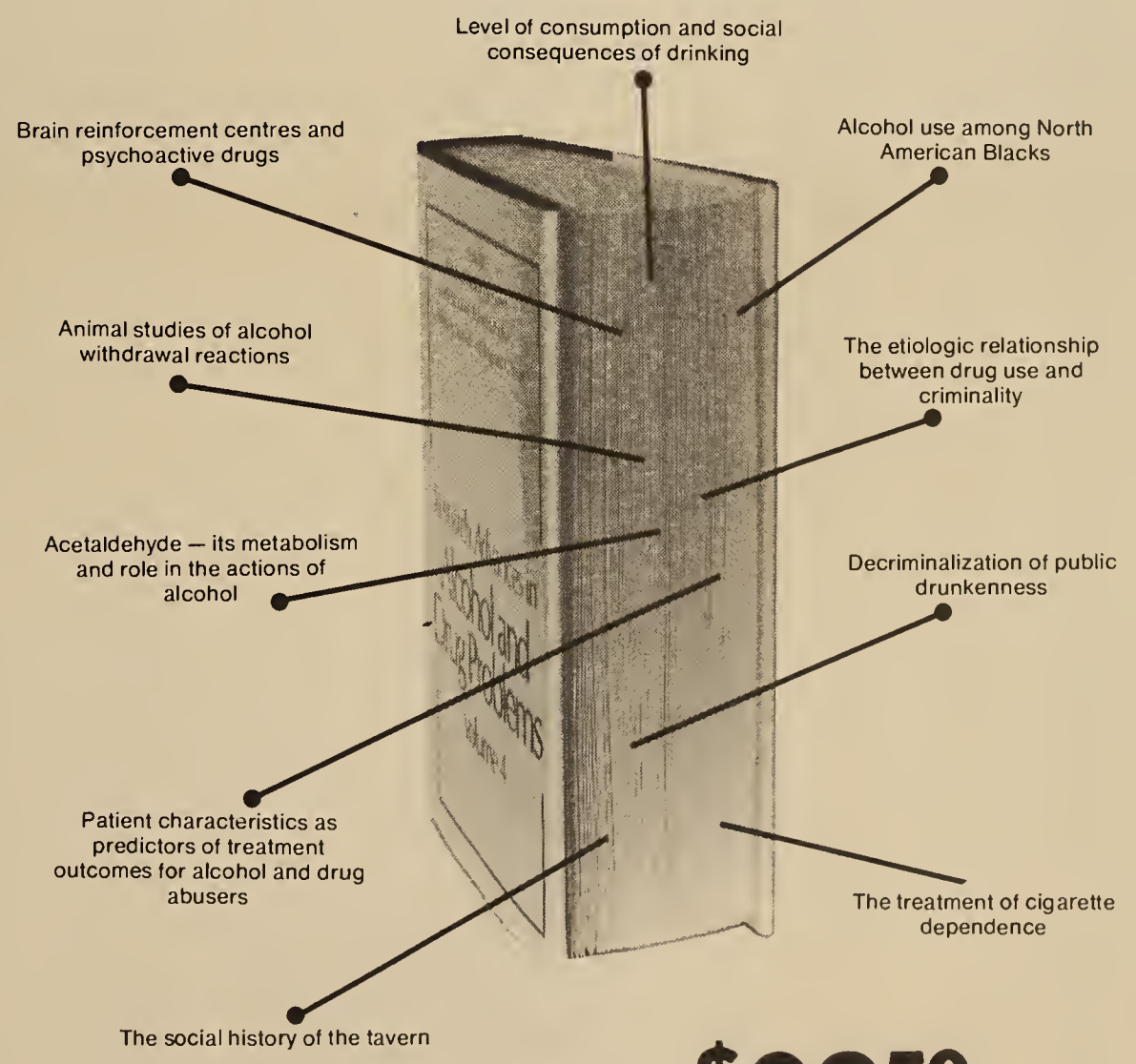
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Old alcohol blues in Boomtown, BC

By Larry Scanlan

CRANBROOK, BC — This is boomtown British Columbia. Unlike other towns in this province's mountainous south central interior, Cranbrook sits on a valley floor, with room to sprawl.

The Purcell Mountains loom at the end of the town's long strip where franchised peddlers of donuts, gas, mufflers, and pizza vie for customers. The neon come-ons are a sure sign of growth.

The only visible hint that alcohol has a stranglehold on this community is a fluorescent sign at a gas station warning of BC's deadliest cocktail — alcohol and gasoline. Nowhere else in BC is that cocktail more deadly. In per capita drinking, and in drinking and driving offences, this area of East and West Kootenay has one of the worst records in a province which already leads the nation on both those counts.

THE BACK PAGE

This year the boomtown of 17,000 — where the average age is only 24 — was crying out for help to alleviate its most insidious and insistent problem. Alcohol.

Until September, there was no government-supported treatment program for alcohol and drug dependence in the entire East Kootenay district, despite the claim by its public health officer that Cranbrook boasted "the highest consumption per capita of alcohol on the North American continent."

Dr Arnold Lowden was later to admit that was perhaps a stretch of the truth. The emotional comment is difficult to prove but yet it stood as a measure of his concern.

Last spring the East Kootenay Justice Council (citizens' groups formed in 1974 in BC to discuss law and its administration) called a public meeting to discuss the problem.

Tales of woe

The council was stunned to see 33 people, from industry, the health professions, the school board, and countless volunteer organizations, file into what must have seemed like a revivalist's meeting. Each had a tale of woe.

- A legal aid spokesman said 75% of their caseload involved alcohol use.
- Chuck Gravelle, a native court worker from St Mary's Indian Reserve, just outside Cranbrook, said 98% of his caseload was alcohol-related. In a later interview, he estimated that of the 200 people on the reserve, "no more than five are ever sober at any one time."
- Family court workers cited alcohol as a factor in 85% of their work.
- Employers and employees representing the logging and mining industries suggested alcohol abuse affected "a very conservative" 5% to 8% of workers.

In an interview with **The Journal**, Bob Sheffield, a Cranbrook family physician and Justice Council member, said 15% of the problems he sees daily involve alcohol. "But it's probably closer to 80% or 90%. If there is pressure, most people will turn to alcohol as a socially acceptable sedative."

Fernie, a logging and mining town of just over 7,000 people, east of Cranbrook, is notorious for its 'frontier' style of drinking. The little burg has 14 places to drink, a fact reflected in its impaired driving totals, which almost equal Cranbrook's — two and a half times its size.

In 1976-77, there were 181 charges laid for impaired driving. That fell to 156 in 1977-78, but the number of alcohol-related accidents climbed from 49 to 69.

Fernie's infamy seems to have reached the BC Alcohol and Drug Commission. After touring East Kootenay last fall, Murray Martin, a liaison worker for the commission, let it be known an organized proposal to the commission for a treatment program would likely win approval. A program has existed in West Kootenay, centred in Nelson, for a year.

Alcohol's toll in this area is not confined to the highways. Dr Sheffield said that in the Elk Valley, where Fernie is the focal point of a population of about 12,000, the rate of family breakup (with alcohol a significant factor) is five per week.

In Cranbrook, the number of single parent families is increasing by 10% each year: currently, one in five children in school comes from a broken home. That figure, says Dr Sheffield, does not include a significant number of parents who work instead of relying on government aid.

Why is alcohol such a crippling social problem in East Kootenay?

To this family doctor, some of the answers are obvious. "There isn't much entertainment other than sports. So entertainment means going out for drinks — the macho thing."

A miner or sawmill worker finishes his shift at 4 pm. "What are you going to do? If you don't go hunting, in season, or drive all the way to Kimberley to ski, what do you do? You drink."

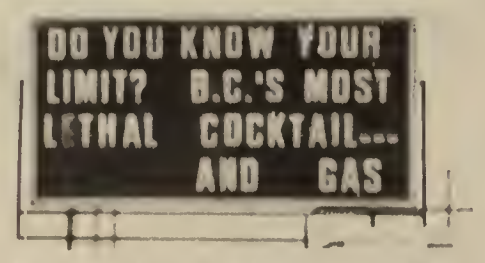
Dr Sheffield, who came here from Saskatchewan, surmises that the hard rock, 'frontier' style of drinking is a carryover from the pioneer days when loggers and miners opened up the BC interior by "workin' hard, fightin' hard and drinkin' hard."

If historical precedent isn't enough, the boom and bust economy of logging and mining, kingpin industries in BC, but especially in the Kootenays, offer more incentive.

A 1976 study in Nelson, a three-hour drive from Cranbrook, noted that the pattern of either work at contract or overtime wages or no work at all "sets up the classic drinking stituation of instant wealth and instant poverty. Payday is still the day of celebration for making it through another week of dangerous or physically strenuous work, and alcohol is still the traditional means of celebrating."

Kimberley, for example, is a dying town dreading the day the ore runs out. The mine in Salmo recently shut down and the only other major employer, a logging firm, has desperately asked the government to take over. For every miner and logger, the threat of strikes, closure, or depressed markets, is constant. "As go forestry and mines," said Dr Sheffield, "so go our communities. Obviously alcohol is the way people deal with their frustration."

The volume of drinking — and here again BC leads Canada in per capita consumption of alcohol — is staggering. Government figures show that for the fiscal year ending March 31, 1977, liquor sales in the East Kootenay electoral district, comprising only five stores, totalled $7,600,000. In West Kootenay, three stores rang up more than $5 million.



Cranbrook roadside warning (above) is aimed at reducing alcohol-related accidents. Seven of eight car fatalities last year involved alcohol.

Although good comparative data on per capita consumption in BC are hard to find, the coupling of eligible voter lists with liquor sales figures for each electoral district gives an inkling of where the Kootenay area stands and it stands very near the top in alcohol consumption.

When that volume of drinking is coupled with the automobile and treacherous mountain roads, the carnage is predictable.

In the absence of good rail and bus service, the car is *the* mode of transport in this sparsely populated region. A few drinks and a missed turn on roads not always guard-railed, and the driver is launched down a mountain side.

The 1976 survey in Nelson by Evans, detected an even more alarming ingredient in the alcohol/gasoline cocktail — speeding, especially by young drivers. Evans cited figures from the Nelson RCMP showing that in 1975, 70% of fatalities among drivers under 20 involved both alcohol and speeding. In the 20 to 29 years age group, that figure rose to 80%.





Heirs of the hard drinkin' traditions of Western pioneer days, practised in saloons such as the Manhattan in Nelson, BC (top), the new pioneers (above) of Kootenay, are setting records for alcoholism and alcohol-related accidents. ('Drinking Team' picture from poster used earlier this year in a BC government blitz against alcoholism.)

Cause for hope

Distances in the Kootenays dictate that high school students must have cars. The number of cars, and above all, 'muscle cars' capable of great speed, is high. The Nelson study pointed out that the rate of acute alcoholism and motor vehicle registrations in BC are both increasing at more than double the rate of population growth.

Inspector Paul Grudniski of the Cranbrook RCMP detachment sees cause for hope.

"I think we're getting through to people," he said. "I hear comments from other officers. They go to parties and they'll hear someone say 'I'll have another drink, so you stop now and you can drive.'" And while last year's death toll on Cranbrook streets was eight, seven due to alcohol, so far this year only one of three fatalities can be blamed on alcohol.

On the East Kootenay Indian reserves, where between 1970 and 1976, 32 of 53 native deaths were alcohol-related, court worker Chuck Gravelle speaks positively of the future.

He said that of the five reserves in the area, with a total population of about 500, the Lower Kootenay Reserve was formerly the worst for alcohol abuse. But the native drug counsellor has achieved spectacular success on that reserve. The band council has also agreed to post peace bonds — bylaws enforced by the RCMP and making it illegal to bring liquor onto the reserve.

A four-and-a-half year veteran of St Mary's reserve, Mr Gravelle will soon resign. There have been too few new offenders in the past year and, therefore, fewer needing counsel. His departure is another positive sign in what has been an otherwise gloomy picture in the past of alcohol abuse by Indians in East Kootenay.

Rafe Mair, BC's Minister of Consumer and Corporate Affairs (which also includes the Liquor Control Branch) was in Nelson in mid-September beating the Socred drum to the party faithful. A likeable, articulate man who admits he has "spilled more whisky than most people ever drank" he has avoided alcohol for three months as part of a diet.

He is well aware BC leads the nation in alcohol consumption and impaired driving. But, when asked if his ministry should take some responsibility for that, he insists "society ought to grapple with the problem" and then wonders if society wants to.

'Not a bad start'

The minister says he is inundated with letters from people who feel this province should have a more "modern" approach to alcohol, or what he calls a "let it all hang out" philosophy. The letters calling for liberalization out-number those demanding restrictions by 10 to one.

He recalled that when he suggested adding five cents to the cost of a bottle of liquor to help defray the cost of a $1.5 million to $2.0 million alcohol moderation program his ministry will announce in three to four months, some people were enraged.

And well they might be. The BC liquor branch in the 1977 fiscal year took in more than $472 million in liquor store sales alone, for a profit of $159 million.

With that profit, is even $2 million for a media campaign to cool the pace of drinking in BC enough?

"It's not a bad start," says the minister.